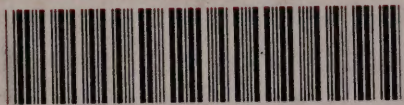


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# Accidents in Hospital Causes and Prevention

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OUTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD



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# Accidents in Hospital Causes and Prevention

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## FOREWORD

This handbook on accidents in hospital has a two-fold purpose. Firstly it is intended to help all hospital personnel to anticipate, and therefore try to prevent, many of the commonplace mishaps which can occur in a hospital as anywhere else. Secondly it is designed as an easy-to-read handbook on the sometimes complicated machinery in dealing with the handling of claims arising out of accidents.

A large number of incidents which have occurred in the area covered by the South East Metropolitan Regional Hospital Board and elsewhere are summarised in the handbook and examples of claims, legal actions, Counsel's opinions and High Court judgments which have followed many of them are also given. It is not claimed that the handbook covers all likely or possible mishaps, but it will be augmented as new cases occur and other matters of interest arise, which would of course include possible changes in the law.

The Board are indebted to the members of the Legal Actions Working Party who regularly advise the Board in the handling of accident claims and, in particular, to the Claims Consultant, Mr. Leonard Baker, without whose invaluable advice and contribution, the compilation of this handbook would not have been possible.

SOUTH EAST METROPOLITAN  
REGIONAL HOSPITAL BOARD  
December 1971

H.N.LAMB  
Secretary to the Board

## CONTENTS

### PART 1

INTRODUCTION . . . . .	1
------------------------	---

### PART 2

#### THE PATIENT

<b>Medical Negligence</b>	
Handling of claims in co-operation with the medical defence societies	3
<b>Treatment</b>	
Wrong operations . . . . .	5
Plasters and fractures . . . . .	7
Foreign bodies (Operations) . . . . .	9
Foreign bodies (Accident injuries) . . . . .	11
Hazards of injections . . . . .	13
Blood transfusions . . . . .	15
Diathermy apparatus . . . . .	17
Lifting of patients in hospital . . . . .	23
Bed sores . . . . .	25
Care and custody of children in hospitals . . . . .	27
Suicidal patients — duty of care . . . . .	29
Unconscious patients . . . . .	31
<b>Consents</b>	
Consent to treatment — General . . . . .	33
Sterilisation . . . . .	37
Human transplants . . . . .	39

### Mentally Disordered Patients

Detained and informal patients absconding and causing injury to persons and damage to property . . . . .	41
Staff attacked by patients . . . . .	43
<b>The Patient — General</b>	
Communications between doctors, nurses and patients . . . . .	45
Patients' property and lost property found in hospitals . . . . .	47
Case notes and records . . . . .	49
Identification of bodies . . . . .	51
Accidents to visitors . . . . .	53

### PART 3

#### BUILDINGS, PLANT AND GROUNDS

<b>Buildings</b>	
Building operations (Ladders) . . . . .	55
Building operations (Scaffolds) . . . . .	59
Building operations (Roofs) . . . . .	61
Glazing in buildings . . . . .	63
Precautions against patients falling from hospital windows . . . . .	65
Maintenance of chimneys used as flues for gas fires . . . . .	67

Safety supervisors . . . . 69

**Plant**

Electrical equipment and appliances 71

Lifts . . . . . 73

Hot water pipes and other heating  
apparatus . . . . . 75

Smut and smoke damage —  
Clean Air Acts 1956 and 1968 . 77

Laundries . . . . . 79

Wheel chairs . . . . . 81

**Grounds**

Falling trees in hospital grounds . 83

Weather conditions — snow and ice . 85

Animals on the highway . . . 87

**Buildings, Plant & Grounds — General**

Factories Act 1961 — application  
to certain hospital premises . 89

Unguarded floor openings . . . 91

Protective clothing . . . . . 93

Vehicles used within hospital  
premises . . . . . 95

**PART 4 CATERING AND**

**DOMESTIC MANAGEMENT**

Accidents in hospital kitchens . 97

Cleaning of urns and vending  
machines . . . . . 99

Slipping on floors . . . . . 101

**PART 5**

**INSURANCE AND INDEMNITIES**

Insurance — General . . . . . 103

Personal protection insurance . . 105

Voluntary helpers in hospital —  
insurance . . . . . 107

Indemnities . . . . . 109

FOR FULL CLASSIFIED INDEX,  
SEE PAGES 111 — 123



**PART 1**

**1.000**

**INTRODUCTION**



## 1.000 INTRODUCTION

In 1952 the South East Metropolitan Regional Hospital Board set up a permanent working party to deal with the conduct and settlement of claims and legal actions arising out of accidents in the region's hospitals.

A paper, entitled 'Mishaps in Hospitals,' produced by the working party and covering the years 1957 — 1962, was circulated by the Board to Hospital Management Committees in 1963.

Since that time, legal action claims have risen steadily in line with the growing number of hospital staff, patients and visitors. In 1949 there were more than 191,000 in-patients treated and more than 1,260,000 out-patient attendances in the region. In 1970 there were 317,000 in-patients and no fewer than 2,967,000 out-patient attendances.

The position has now been reached where the Board's legal department has more than 100 cases under active investigation at any given time. These cover a wide range of mishaps, of varying degrees, involving patients, staff, visitors and other people with access to hospital premises.

Hospitals are as vulnerable as industry and other sectors of working life where the human element plays so great a part in their activities, but to prevent accidents it is first necessary to know how they are caused. Accordingly at the request of the working party a more comprehensive survey of accidents and legal action claims in the region has now been undertaken and forms the subject of this handbook.

A survey of this nature will not of itself eliminate mishaps, but it is hoped that, given the widest possible circulation and availability for discussion, the cases described in the document will help to focus attention on the day-to-day hazards and so lessen the risk of further

similar mishaps.

Early in 1969, in order to help to streamline a process by which Hospital Management Committees at first sifted claims and referred them to their own solicitors, the Board introduced a centralisation scheme by which all legal action claims are routed to the Board to be considered in the first instance by the Board's claims consultant and then, if necessary, referred to the Board's solicitors.

With the helpful co-operation of participating Hospital Management Committees the scheme has operated successfully and many claims have been disposed of without involving Hospital Management Committees in any legal costs.

A considerable fund of knowledge is available and specialised expertise exists throughout the various phases of the scheme. All claims are considered by the Board's working party.

One of the essentials for success in investigating circumstances giving rise to possible claims is speed and detail in recording and reporting all the relevant facts. Comprehensive and detailed guidance on this subject was circulated in a letter to all Hospital Management Committees on 13th December 1968.

The Board's legal department is always available to give any preliminary advice and guidance when required, particularly in the initial stages of investigation.

**PART 2**

**2.000**

**THE PATIENT**



## **2.001 MEDICAL NEGLIGENCE**

## **2.002 HANDLING OF CLAIMS**

Medical negligence includes such matters as negligent treatment, failure to diagnose or wrong diagnosis. The handling of claims under this heading is largely a matter requiring consultation with the medical defence organisations, bearing in mind their agreement with the Department of Health and Social Security as set out in Circular HM (54) 32.

Claims involving medical cases, which are so often highlighted by the press, continue to increase as the public become more and more claims-conscious. If proof of this tendency is needed, it will be found in the statistics and variety of cases referred to in the annual reports of the defence organisations.

Nevertheless, quite a number of cases arise where, for one reason or another, the liability devolves on the Hospital Management Committee as well as the doctors concerned. A Hospital Management Committee may well become involved when it can be proved that negligence or failure of duty of staff other than medical has contributed to the patient's cause of action.

In this category are such cases as failure on the part of theatre nurses to account for swabs and surgical instruments, providing over-heated surgical instruments, blood of an incorrect group, and wrong or over-doses of drugs asked for and administered by a doctor. Instances of cases for which the hospital authority could be partly responsible may include those where a surgeon has been supplied with equipment, parts of which have become detached while in use and foreign bodies left in the patient's body. A case in point was that where a small bulbhead was left in the patient's body after the operation. Again, there was a case where during a tonsillectomy the nurse handed the surgeon some sterilised rods which were over-heated to the extent that when applied, the patient suffered burns to the neck.

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## **2.100 TREATMENT**

### **2.101 WRONG OPERATIONS**

In 1962, the South East Metropolitan Regional Hospital Board expressed strong concern about wrong operations. The Board particularly cited the cases of two postmen who each had a wrong cartilage removed. There was also a case in which as the result of confusion over two patients a minor operation intended for one was performed on the other although fortunately after the first incision the mistake was discovered before the wrong operation proceeded further. There have been other cases of a wrong eye operation and removal of the wrong ganglion.

Since 1961, the Medical Defence Union and the Royal College of Nursing have published a number of joint memoranda on safeguards against wrong operations. In 1968, the then Ministry of Health, drawing attention to the 1966 version of the joint memoranda, reminded hospital authorities of the importance of laying down and adhering to a clearly defined routine in connection with operations, and of ensuring that all the staff concerned know it and follow it. In spite of this, as the annual reports of the medical defence societies indicate, wrong operations still occur.

The Medical Defence Union in 1964 produced an excellent film, 'Make no Mistake,' illustrating the steps that ought to be taken to lessen the possibility of a surgeon performing the wrong operation, and Hospital Management Committees who have not already done so would find the showing of this film helpful in giving useful instruction for staff.



## 2.102 PLASTER AND FRACTURES

The dangers of plaster of paris causing constriction of a limb and serious complications have been emphasised many times in the past, and are illustrated repeatedly in the annual reports of the defence societies.

These problems can arise in the treatment of fractures or where plaster of paris, or even tight bandages, have been applied after an operation. They can have grave consequences, including gangrene and loss of the limb.

Often responsibility in these cases is shared between the surgeon and the Hospital Management Committee, the latter usually because of some failure by the nursing staff to exercise enough close supervision of the limb and its circulation after application of the plaster and to warn the medical staff immediately on the appearance of any danger signs. It is vitally important to maintain accurate nursing records of such events.

Another type of case in which responsibility may be shared between a doctor and the Hospital Management Committee is where a fracture is missed in the casualty department and the patient sent home. The radiologist reporting on the x-rays later may correctly diagnose the fracture. If his report fails to reach the casualty department, and/or if prompt action is not taken to recall the patient for treatment of the fracture, the Hospital Management Committee will be regarded as negligent for the failure of its organisation in these respects.

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## 2.103 FOREIGN BODIES (OPERATIONS)

There are three broad classes of mishap, any one of which could be the subject of a legal action claim, when foreign bodies are left in the patient during an operation.

In the first type, the surgeon by design leaves an article in a patient, whether temporarily or permanently, for therapeutic reasons. A recent case, occurring in private practice outside the region and which received wide publicity, involved an experimental operation aimed at improving a woman's hearing, but which, unfortunately, failed to achieve the desired result.

In the second type of case, the surgeon leaves an object inside the patient, in the latter's best interest. This is usually after repeated unsuccessful attempts at removal when it is considered wiser, on balance, to end the operation with the object retained by the patient than to go on trying to remove it.

In a case dealt with recently by this Board, a patient, from whom a small part of a needle (which broke during the operation) could not be removed without endangering her safety, claimed damages because of alleged resultant anxiety. The manufacturers, on testing the batch of needles from which the one in question was taken, found it to be faultless. The consultant later reassured the patient of the unlikelihood of any adverse effects while his defence organisation were of opinion that this was a recognised hazard of surgery, not necessarily implying lack of surgical skill or care.

The third type of case concerns articles accidentally left in a patient. Such cases continue to occur despite the advice and publicity given on theatre procedures. The objects concerned may be swabs, surgical packs, surgical instruments and other appliances. Difficulty can arise in deciding whether, or to what extent, the accident is a factor contributing to the adverse effect.

An example of the retention of a surgical pack in a patient occurring in the experience of the Board shows how easy it is for human errors to creep into the exacting conditions of the operating theatre, despite adoption of thorough precautionary methods. It was subsequently ascertained that a swab count had not been carried out in accordance with the prescribed procedure. The position was further complicated because

although the abdominal pack had a marking strip which was clearly evident on the x-rays, this was not detected when the x-rays were reported on as the radiologist had no indication that a foreign body was present and mistook the strip for a piece of drainage material.

Another source of confusion over the identification of swabs is the mistaking of internal swabs for external or skin dressing swabs. Following another legal action, Hospital Management Committees were advised to encourage the use of coloured skin-dressing swabs (green was suggested) which should not contain a radio-opaque filarient, since an internal swab with similar indicator could be confused for an external one on an x-ray film, and so be left in the patient. The added precaution was advised of ensuring that skin dressing swabs do not reach the operating table until closure of the wound.

General preventive measures as advised by the Medical Defence Union and the Royal College of Nursing, in their joint memoranda, were brought to the attention of all Hospital Management Committees in the region in 1963 and 1967.

## 2.104 FOREIGN BODIES (ACCIDENT INJURIES)

The delayed discovery of a foreign body in a wound can sometimes lead to a claim for negligent treatment. One of the most common causes for complaint under this category is the fact that pieces of glass are overlooked in injuries. In the 'Lancet' for 10th October, 1970, reference was made to the anxiety felt by both the Medical Protection Society and the Medical Defence Union about glass in wounds. Their joint message advocates, 'Do not neglect to take an x-ray,' while in the words of the Medical Defence Union, 'it is surprising how often pieces of glass are overlooked in injuries resulting from attempts to open or shut windows or from falls against glass doors. Many practitioners do not realise that all glass is, in varying degree, radio-opaque .... and the possibility of its presence should be pointed out to the radiologist.'

The Medical Protection Society is less dogmatic: 'Almost all glass in common use is sufficiently radio-opaque to give a shadow when in soft tissues .... The degree of opacity varies with the composition. The few which may not produce a shadow on x-ray examination include some of the high soda translucent tubular lights of American pattern, some of the textile glass fibres (Borates), and a few special glasses not likely to be met in everyday life.'

The importance of taking x-rays when accidents have occurred, and the presence of foreign bodies such as glass, china, grit, splinters, metal filings is suspected, cannot be too strongly emphasised. Claims in which the Board have become involved have included a case in which a piece of china was left in a facial wound and another in which glass was left in the patient's forehead following treatment after a road accident.



## 2.105 HAZARDS OF INJECTIONS

It seems there are four main ways in which errors can render injections harmful to patients. Firstly, an incorrect drug is used, perhaps because the label was insufficiently checked or the ampoule was mislabelled. Secondly, the solution of the drug is at fault, owing to failure to make it up or dilute it appropriately. Thirdly, the drug is administered wrongly, whether by reason of technique, or by mistaking the location on the patient, for instance a muscle instead of a vein. Fourthly, the needle breaks during the injection.

In illustrating such hazards, one is most concerned with those accidents which might have been prevented through adherence to certain procedures. In recent years, hospitals have probably experienced most difficulty with the second type of error, in which the solution or dosage of the drug is incorrect.

In a recent case an injection was given straight from an ampoule opened in the theatre, although it is unusual for solutions to be made up in the theatre itself. During the operation the patient, who later died, was given a drug in undiluted form because of a verbal misunderstanding between the surgeon and a staff nurse.

Hospital Management Committees have been reminded that it is the responsibility of the person giving the injection to verify the label on the container and to ensure that the drug came from that container. It is not enough to rely only on verbal assurances given by other people and a circular to this effect was sent to Hospital Management Committees in January, 1971.

As far as general precautionary measures are concerned, the Department in Circular HM (58) 17 re-iterated the advice given by the Central Health Services Council with regard to measures necessary to reduce the dangers of such incidents, and Hospital Management Committees are reminded of the importance of staff being advised at regular intervals to bear in mind the points made in this Circular.

The Committee have been reminded that the responsibility for the label on the container and the information on the verbal statement given by the Committee in January, 1971, is on the Committee. The Committee is requested to ensure that the label on the container and the verbal statement given by the Committee are consistent and that the information is clear and unambiguous. The Committee is also requested to ensure that the information is consistent with the information provided by the Central Health Service Council with regard to the incidents and hospital admissions. The Committee is also requested to ensure that the information is consistent with the information provided by the Central Health Service Council with regard to the incidents and hospital admissions. The Committee is also requested to ensure that the information is consistent with the information provided by the Central Health Service Council with regard to the incidents and hospital admissions.

## 2.106 BLOOD TRANSFUSIONS

There have been a number of cases during the past few years involving the giving of the wrong blood to patients. Invariably this has been due to human failure to carry out the correct procedures, although in some respects the procedures have been inadequate.

In one instance blood was prepared for two patients in the ward with similar names. The forms for both patients were lying on the ward sister's desk and the staff nurse picked up the wrong form with the result that the blood correctly grouped for one patient was given to the other patient who subsequently died. In another case a patient during the course of an operation was given the blood of a wrong group because despite different coloured labels having been adopted for different groups, the incorrect bottle was taken from the refrigerator.

In yet another case a patient was transferred from one bed to another during the night, but the bed state record was not altered to show this change which took place on account of the admission of a comatose patient. Because of this, blood required for crossmatching was taken from the wrong patient with the result that incompatible blood was transfused.

These cases indicate the importance of Hospital Management Committees introducing and maintaining a procedure which will ensure that blood of the correct group is given to the correct patient. The procedure adopted should ensure that the following points are covered:

1. the correct information relating to the patient's name, age, ward and patient's number is recorded on the pathological request form;
2. the blood specimen is correctly labelled with the patient's name, ward, number and date;
3. the crossmatch request card is checked to ensure that it is correct;
4. the crossmatch report subsequently received is attached to the correct patient's notes;
5. when bottles of blood are collected from the laboratory, the patient's notes with the crossmatch report are presented before issue is made ;
6. each person concerned with the transfusion checks that details of the blood, crossmatch label, the patient's label and documents agree and this is confirmed by another person.

The importance of distinguishing colours of the labels of the different blood groups is aptly illustrated in the film, 'Blood Groups and Transfusions' (U.K.1776) about which the Board wrote to Hospital Management Committees on 4th September 1968.

## 2.107 DIATHERMY APPARATUS

The working party in its 1963 report, 'Mishaps in Hospitals,' stated that accidents concerning diathermy figured prominently in four cases and what was then stated bears repetition.

A patient who sustained a third degree burn during short wave diathermy treatment in the physiotherapy department had been asked to report if she felt undue heat, but had not been warned of the danger. There have been similar mishaps in which patients have alleged that they were not properly warned of the dangers if they failed to report undue heat. (*Advice based on Counsel's opinion is given at the end of this section*).

The other cases were attributable to the use of a diathermy pad during surgical operations under a general anaesthetic. The reason was obvious in one case, because the lead terminal which should have been bandaged in on the patient's arm was afterwards found lying on the floor. In another case the earthing of the endotherm unit was later found to be faulty. The reason was more difficult to establish in the fourth case. Here the patient was found to have a large blister near the shin, although the diathermy pad had been applied to the thigh.

Accidents continue to happen and the following three cases illustrate the need for continued vigilance in the exercise of safety precautions.

A patient was lying on the operating table with his legs apart, his bare feet being supported and strapped to metal brackets attached to the operating table. Two sections of the table had been removed to enable a mobile x-ray apparatus to be positioned between the patient's legs. The x-ray machine was draped with towelling during the operation so that its exact position, relative to the patient's legs, was not apparent. The diathermy (G.U. Brompton table) was used several times during the operation. The plate electrode was completely enclosed in a saline soaked lint pad and attached to the left thigh. At the termination of the operation the plate electrode was removed and nothing unusual was noted concerning the condition of the patient's legs.

However, some time after the patient was returned to the ward a severe burn some three inches in diameter was noted on the inner aspect of the patient's right calf. Diathermy current flowing into the patient from the active electrode will seek to return to earth via any path encountered. Exposed metal parts on

the x-ray apparatus have a direct earthing connection and if any parts of the machine came into close proximity of the patient, leakage current would flow to earth via the machine. The x-ray apparatus was positioned between the patient's legs and was covered with towelling. It would appear probable that it came into contact with the patient's right calf without being detected.

In the second case, the patient was lying straight out on the operating table. Diathermy was used on several occasions during the operation, the plate electrode enclosed in a saline soaked pad was attached to the right thigh. It is understood that, due to the nursing staff not being informed beforehand that a bone graft was to be carried out, only one instrument table was prepared, and some instruments, a bowl and tools including a heavy metal mallet, were placed on the towelling between the patient's legs.

Although no sign of any burn was seen whilst the patient was in the operating theatre, subsequently in the ward a burn consisting of three separate blisters was noted on the inner aspect of the patient's right calf. In this instance there was no evidence of any directly earthed metal coming into close contact with the patient's legs. The metal objects which were placed between the legs, particularly the larger items such as the mallet and stainless steel bowl, would be capable of forming a capacitive link in a path to earth via the patient's legs and operating table.

Under these conditions, only comparatively small diathermy leakage currents would flow, but if these are concentrated over a comparatively small contact area on the patient for a sufficient period of time, a burn could result. In the absence of any other possibility it is concluded that the burn was due to metallic objects placed between the patient's legs forming a capacitive path to earth.

Commenting on these two cases the then Ministry of Health Electrical Safety Engineer made the following observations: 'The incidents illustrate the dangers of allowing extraneous metal to come into contact or within close proximity of patients whilst diathermy is in use. Ideally all metal other than electrodes should be spaced the same distance from the patient, i.e. the thickness of the operating table pad, in order to prevent the possibility of small high current density areas of contact. In practice it may not be practicable to achieve equal spacing but the spacing should not be of less than one quarter of an inch and insulation should be used where necessary to ensure this. There is no objection to anti-static rubber being used to

insulate patients for diathermy purposes.'

The third case concerned a patient who was admitted for an exploratory laparotomy. An appendicectomy was performed and the abdomen closed. A diathermy pad was applied to the right thigh during the operation. At one point the surgeon accidentally put his foot on the diathermy pedal and the patient sustained burns on both legs because the unprotected metal end of the diathermy point was resting on the metal end of the suction apparatus across the patient's towelled legs. Apart from this action of the surgeon it was also alleged that the hospital were guilty of a failure of duty since no quiver, in which the suction and diathermy ends could be enclosed, was provided for use on the trolley. Indeed, on the morning in question, the two available quivers were both being used in another theatre. The surgeon's defence organisation accepted 80% responsibility whilst the Hospital Management Committee contributed 20% toward the cost of the resultant claim.

In the matter of fire hazards, Hospital Management Committees are reminded of the guidance given in Hospital Equipment Information notes. An extract from Hospital Equipment Information No.2 (May, 1963) reported that two fires had occurred in interior sprung mattresses after patients lying on them had received treatment with short wave diathermy. The fires were caused by sparking between springs of the mattress which ignited the filling material, the sparks being due to the difference in electrical potential induced in the springs by the high frequency electric field between the diathermy electrodes.

Because of this risk short wave diathermy treatment should not be given to patients on an interior sprung mattress. Treatment on metal framed furniture should be avoided because of the possibility of burns occurring if the patient contacts the metalwork, and attention is also drawn to the need to keep metal objects and electric cables out of the electric field associated with short wave therapy equipment.

An extract from Hospital Equipment Information No. 21 (October, 1967) recalled that HM (56) 36 on hospital fire precautions drew attention to the need to ensure that short wave therapy machines are not used in close proximity to metal incorporated in inflammable materials.

A minor fire involving a short wave therapy unit has recently been reported in which the cause was the close proximity of the unit's flexible mains supply cable to the high frequency cable to one electrode. The

intense high frequency electric field between the two cables resulted in overheating and ignition of the cable insulation.

The hazard which resulted in this incident is well known. However, it was felt to be worth-while bringing it to the attention of users as a reminder of the need to keep electrical leads, and metal objects generally, away from the electric field associated with the diathermy electrodes and their connecting leads.

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### Warning to Patients on Diathermy Dangers during Physiotherapy Treatment

*Counsel has expressed the opinion that any warning to patients receiving heat treatment should be couched in terms that make it abundantly clear that it is a warning of danger and that the patient's safety depends upon his informing the person administering the treatment immediately he feels more than a comfortable warmth. Patients receiving medical diathermy should be given an appropriate warning when being instructed in the use of the safety switch, if fitted, and should always be asked if they have understood the warning.*

*The warning to patients receiving the various forms of heat treatment need not follow any precise formula but must cover the following points:*

- (a) the sensation the patient should feel;*
- (b) the sensations they might feel if the heat were too great;*
- (c) what to do in the latter case;*
- (d) the risk of serious burning in the latter case;*
- (e) the necessity of staying awake.*

*It was considered that it was unnecessary to require patients to sign a form stating that they had received the warning, but that notices in the following terms should be displayed prominently in treatment rooms:*

*'When undergoing heat treatment you should feel no more than a pleasant warmth. If you feel any unusual sensation such as cramp, pain or too much heat you should call an assistant at once. Failure to do so could lead to serious burning. Do not go to sleep during treatment.'*

*In addition, a small notice should be affixed to each diathermy machine so that it is readily visible to the patient:*

*'When undergoing diathermy treatment you should feel not more than a pleasant warmth. If you feel any unusual sensation such as cramp, pain or too much heat you should (switch off the machine and) call an assistant at once. Failure to do so could lead to serious burning. Do not go to sleep during treatment.'*

*NOTE. The reference in brackets to switching off the machine will apply only to diathermy apparatus fitted with a patient operated safety switch.*

*It is not considered necessary to have safety switches fitted to existing machines provided that they are only used when the responsible physiotherapist is close at hand and within certain earshot. When purchasing new apparatus Hospital Management Committees should stipulate that a patient operated safety switch must be fitted.*

*The Board is anxious that the attention of all staff concerned is drawn to the necessity of following the procedure recommended by the Board's legal advisers and a system should be adopted whereby all physiotherapy staff should sign that they have read and understood the code of practice to be followed in the use of heat for therapeutic purposes. It should be stressed that the application of heat must be confined to trained personnel and under no circumstances should untrained assistants undertake these duties.*



## 2.108 LIFTING OF PATIENTS IN HOSPITAL

The Board are frequently called upon to investigate and deal with claims following accidents to nurses resulting in back injuries when lifting patients. Almost invariably the allegations against the employing authority are that the patient was abnormally heavy and required more than the usual number of nurses to accomplish the lifting operation safely. In some instances it has been argued that the injured person had never received proper instructions as to the correct lifting procedure while in other cases, involving helpless patients, it has been maintained that special hoist or lifting devices should have been made available in the wards. For the most part, when investigations are carried out, it has transpired that the allegations are unfounded and the injury has resulted from what legal opinion suggests is merely an occupational hazard for which, in the absence of provable negligence and/or breach of duty, the employers cannot be held liable.

There have also been those occasions when it has come to light that, unknown to the hospital authority, the nurse has suffered from previous back trouble which has been subsequently exacerbated by lifting operations well within the physical capacity of the normal person.

Having said this, it must be conceded that there have been isolated cases where undue strain has resulted from shortage of staff on a ward such as where —

1. in the absence of other available staff a nurse was called upon to lift suddenly and single-handed a patient who was on the point of falling out of bed, and,
2. during a meal break only one nurse was left on duty in a ward and during this period she was called upon, as a matter of urgency, to transport a patient in a wheel chair to the toilet and when endeavouring to assist in getting him on to the toilet seat she strained her back.

Another case where liability had to be accepted was where two nurses lifted a patient in the process of which one nurse relinquished her hold thereby leaving the other nurse with the whole weight of the patient.

Some useful hints on 'Lifting Patients in Hospital' can be found in a booklet produced by the sub-committee on posture and lifting of the Chartered Society of Physiotherapy. The booklet contains photographic illustrations of what are termed the 'Orthodox Lift' and the 'Shoulder Lift.'

The nurse training films, 'Lifting of Patients in Hospitals,' and its second part, 'Poise and Movement,' obtainable from the Central Film Library, (Government Building, Bromyard Avenue, Acton, London.W.3.) explain the mechanics of lifting and how injuries can be caused if the incorrect procedure is used. Camera Talks Ltd, (31 North Row, London W.1.) have also produced the following 35mm film strips in colour:

'Lifting and Handling of Patients'

'Posture and Lifting' (Two films)

'Lifting in Hospital' (Two films)

The introduction of a continuous programme of in-service training on lifting, including the use of mechanical hoists where these are available, will ensure that all staff are fully conversant with the correct procedures.

## 2.109 BED SORES

Allegations of negligent treatment were made in a particular case where a patient upon admission to hospital was heavily sedated and subsequently bed sores developed. Although it was very doubtful whether the bed sores could have developed in such a short period of time following her admission to hospital, difficulty was experienced in rebutting the allegation because the medical and nursing notes on admission made no reference to the presence of bed sores, although some 36 hours later a reference was made that bed sores had been present on admission.

The importance of proper records being made in the medical notes on the admission of patients at risk — especially unconscious or geriatric patients — and the information being passed on as a routine when a patient is transferred, was stressed in the advice given by the Board to Hospital Management Committees in January, 1968 as follows:

At their last meeting the Medical Advisory Committee of the Board considered the matter of pressure lesions, which had been raised at a regional matrons' meeting following the receipt of two complaints, relating to a psychiatric and a general hospital respectively. Particular concern was expressed that proper records be made in the medical notes on admission of patients at risk — especially unconscious or geriatric patients, and that such information be passed on as a routine on transfer of the patient. The Committee have asked that matrons and chairmen be advised that pressure lesions, or potential pressure lesions, should continue to be brought to the attention of medical staff by the nursing staff and that medical staff should be responsible for prescribing preventive measures and treatment when required, for maintaining written records, and for passing on this information when patients are transferred.



## 2.110 CARE AND CUSTODY OF CHILDREN IN HOSPITALS

Over the years there have been a number of cases involving the care and custody of children in hospital wards and premises. Arising from three recent claims, the Board's working party have exercised their minds as to whether any guidance on this subject can be given to Hospital Management Committees in the region. Some hospital officers may be familiar with the circumstances giving rise to the decided case of *Gravestock-v-Lewisham Group H.M.C. (1955)*. This was a claim in respect of a child in-patient at the Lewisham Hospital who ran into a glass door and was injured. The accident was alleged to have been caused because the child — a girl — was being chased by a boy with a dead mouse. Mr. Justice Streatfeild held that this version of the circumstances was not true but that the child was running down the ward and swinging on the doors and had tripped on a stud.

Another accident involved a child at a children's hospital, who was scalded by pulling the contents of a hot water jug over himself while in the care of his parents. The jug containing the water had been left by a nurse on a locker situated behind the spot where the mother was seated with the child in her arms.

In a further incident a child was in a waiting room with his parents, and, while they were watching television, the child fell off a chair and suffered an eye injury. The particular Management Committee concerned asked for some specific guidance to the nursing staff, bearing in mind the fact that many parents now voluntarily visit hospitals to feed, entertain and generally help with the care of their children when they are in the wards. There are also those occasions when parents perform services for other patients in the wards.

This enquiry raises a two-fold issue:

- (a) the duties of hospitals to provide proper supervision for children in a children's ward; and
- (b) accidents occurring in children's wards in which parents voluntarily perform some service to their own children and, on occasions, to other child patients in the ward.

So far as (a) is concerned, this question was gone into very thoroughly by Mr. Justice Streatfeild when giving his judgment in the case of *Gravestock-v-Lewisham Group H.M.C.*, referred to above. The view expressed by the Judge can be summed up in the sentence which reads: 'I cannot think that the duty of a

Hospital Management Committee is any higher than that of people in charge of a school, and in my judgment, although the matter, as far as I know, has never been judicially laid down, I am not prepared to measure the duty on the defendants here by any more severe yard-stick than that which applies to school masters, and in my view their duty is that of ordinary prudent parents.'

Regarding (b) as far as voluntary duties by parents generally are concerned, it is difficult to be specific in defining the possible liability question, since so much depends on individual circumstances necessitating every case being considered and dealt with on its particular merits. Excluding medical matters, it seems it would be most difficult to define adequately the limits of the parents' activities and one can only hope that, in the main, they could be relied upon to act as responsible and prudent parents, and certainly do nothing that would be prejudicial to the child's medical or surgical treatment. To this extent, it would be difficult to lay down any specific guidance to the nursing staff.

Hospital Management Committees would be well advised to bear in mind injury hazards when choosing furniture etc. for children's wards, and the desirability of placing furniture in such a position that it cannot be used by children to climb on to unprotected windows etc. Suitable precautions should also be taken to prevent children having access to other obvious hazards, for example clinic rooms, ward kitchens and stores where cleaning equipment and caustic liquids might be stored.

## 2.111 SUICIDAL PATIENTS : DUTY OF CARE

One of the most vital responsibilities of hospital authorities is the care of patients with known suicidal tendencies. Following the case of *Selfe-v-Ilford and District Hospital Management Committee (QBD)* (1970) the Department of Health and Social Security submitted the following observations on the general implications involved:

'In June 1966, Alan Selfe, aged 17, was — following an apparent attempt to commit suicide by taking an overdose of drugs — a patient in a general ward in a general hospital awaiting transfer to a psychiatric hospital. He left his ward and, in falling from a roof, suffered injuries which left him paralysed from the waist downwards. He sued the H.M.C. for negligence and in an action in the High Court the H.M.C. were held to be negligent in not providing a reasonable standard of nursing care in a ward containing patients who were suicide risks. The judgment specified numerically the standard of nursing care which should have been provided in that ward, viz that in a ward containing four potential suicide cases there should be three nurses actually in the ward on duty all the time. There were, in fact, three nurses on ward duty at the time the patient escaped from it but only one was actually in the main ward and she was attending to another patient.

'The case received publicity in the national press and has aroused considerable interest throughout the hospital service. This interest has been centred mainly upon the numerical standard of nursing care which the case seemed to lay down with particular reference to suicide risks. In the opinion of the Department, the decision in this case turned on its own particular facts and need not be regarded as having more general application. The case which, in the opinion of the Department, lays down the standard of care which is of universal application and which was, in fact, relied upon in the *Selfe* case is that of *Thorn v. Northern Group H.M.C.*, a report of which appears in (1964) 108 S.J.484. The relevant passage from the judgment in that case reads:

"The duty owed by hospital authorities and staff to a patient is that of reasonable care and skill in the given circumstances. Whether a breach of that duty has been established depends on the proved facts, including what was known, or should have been known, about the particular patient and the fact that

the defendants impliedly undertook to exhibit professional skill and administrative care of reasonable competence and adequacy towards their patient. They must take reasonable care to avoid acts or omissions which they can reasonably foresee would be likely to harm the patient entrusted to their charge; but they need not guard against merely possible (as distinct from reasonably probable) harm. On the other hand, a degree of care which will be regarded as reasonable is proportionate both to the degree of risk involved and to the magnitude of the mischief which may be occasioned to the particular patient in the absence of due care."

'Each hospital authority has to take such care of individual patients as is reasonable in all the circumstances of the particular case. This is clearly incapable of precise numerical definition or of being reduced to a formula applicable to all cases. It is not intended to attempt any such definition or to give further guidance on the standard of care which it is thought would be sufficient to avoid legal liability in any particular case.'

All staff concerned with the care of patients must be made fully aware of the standards expected of them particularly having regard to the observations which have now been made by the Department.

Each case must be considered on its individual merits and the form of care and attention must be such as to ensure the best interests of the particular patient. If, for example, he is known to have suicidal tendencies he must be carefully watched at all times so as to prevent him from being able to harm himself.

## 2.112 UNCONSCIOUS PATIENTS

The need for proper care in the conveyance of unconscious patients and their treatment within wards and departments is illustrated by two particular cases. In one of these a patient suffering from an overdose was admitted as an emergency to the casualty department and transferred by the ambulance men to a trolley. Subsequently it was necessary to move the patient to another room and as the trolley was being moved the patient convulsed and fell between the trolley and a wall. In another case a trolley was left unattended for a few minutes and during this period the patient fell off the trolley. Both these cases show the importance of trolleys being fitted with safety side rails, of staff being constantly in attendance when patients are unconscious, and for trolleys to be fitted with locking wheels to avoid being tipped.



## **2.200 CONSENTS**

### **2.201 CONSENT TO TREATMENT**

The Department of Health have reached agreement with the British Medical Association, the Medical Defence Union, the Medical Protection Society and the Medical Defence Union of Scotland, on the adoption of a standard consent form for use in the generality of medical and dental procedures for which consent is required. The importance of obtaining a fully informed consent has been emphasised by the Department, and the Medical Defence Union have pointed out that from the legal point of view it is essential that the person consenting must understand to what he is giving consent. Unless the patient is told the nature and effect of the operation, he may afterwards repudiate the consent form on the grounds that he did not fully appreciate the implications of the document that he was asked to sign.

In the case of operative procedures not covered by the standard consent form, the type of special consent form used should conform to the advice given by the medical defence societies.

A number of enquiries have been received concerning the obtaining of consents in particular circumstances, and the following brief notes summarise the general position:

- (a) The Family Law Reform Act of 1969, provides that the age for consent to any surgical, medical or dental treatment is now 16 years, and therefore, in the case of patients of this age and over, the patient's own consent should normally be obtained.
- (b) In the case of children under the age of 16 years, the consent of the father, mother or other guardian should be obtained. It should be noted that in cases where a child has been committed to the custody and control of a local authority, then the proper officer of that authority is the person to give any requisite consent.
- (c) If the patient is unconscious or in no state of mind to consent or object the consent of a spouse or a near relative should be sought but if no spouse or near relative is readily available and the patient is in need of an urgent or life-saving operation, the surgeon should render any treatment that is immediately necessary in the best interest of the patient. The general consensus of opinion is that in these circumstances such action would be supported by the courts, and the same applies in the case of children requiring urgent treatment, whose parents or guardians are not

immediately available to give consent.

- (d) In the case of mentally disordered patients, the form of consent necessary depends upon the category of the patient in accordance with the Mental Health Act 1959.
- (e) In cases where parents refuse consent to a life-saving blood transfusion or operation for a child, hospital authorities should rely on the clinical judgment of the consultants concerned after full discussion with the parents. Guidance on the procedure to be followed will be found in the following letter from the Ministry of Health dated 14th April, 1967:

'Representations have been received from local authority associations about the difficulties that may arise when parents refuse consent to a life-saving blood transfusion or operation for a child. Hospitals are still on occasion asking the local authority to bring the child before a juvenile court as being in need of care, protection or control with a view to a fit person order being made under the Children and Young Persons Acts.

'It appears that the Departmental advice circulated to Board Secretaries and Senior Administrative Medical Officers in 1961 and referred to in Ministerial replies to Parliamentary Questions on 27th March, 1961, and 14th February, 1966, may not have been sufficiently widely known in hospitals.

'This advice is that hospital authorities should not in such cases resort to this procedure for the purpose of obtaining a consent to life-saving blood transfusion or operation. This procedure was not devised with this purpose in mind and there are a number of legal and practical difficulties about its use for this purpose. In particular, it has not been established in the higher courts whether the consent of a fit person to whose care a child has been committed by order of a court provides any added protection to a doctor who carries out a life-saving operation or blood transfusion in the face of continued parental opposition. Moreover, it may not be possible to complete the procedure in time.

'Hospital authorities should therefore rely on the clinical judgment of the consultants concerned after full discussion with the parents. If in such a case the consultant obtains a written supporting

opinion from a colleague that the patient's life is in danger if operation or transfusion is withheld, and an acknowledgment (preferably in writing) from the parent or guardian that despite the explanation of the danger he refuses consent, then the consultant would run little risk in a court of law if he acts with due professional competence and according to his own professional conscience, and operates on the child or gives the child a transfusion.'

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## 2.202 STERILISATION

Special forms of consent as recommended by the medical defence societies should be used in cases where an operation for sterilisation is to be performed. While the consent of the spouse to the performance of an operation on the other partner is not necessary in law, it is desirable where sterilisation is to be undertaken that the spouse should be informed of the nature and effect of the operation and should be asked to sign an acknowledgment that he or she agrees to it. If, however, the operation is to be carried out on therapeutic grounds it is not essential in law to obtain the consent of the spouse.

There have been two cases recently where claims for damages have been made. In one, the patient did not complete a consent form but otherwise intimated agreement to the operative procedure being carried out. In another, the husband and wife were interviewed and agreed to sterilisation but unfortunately the hospital staff failed to get the form of consent signed. Subsequently the husband complained about the operation being performed on his wife without his consent. In both cases difficulties arose in proving that oral consent was given. There is also the added difficulty that in oral consents misunderstanding can arise due to language and communication problems.

This stresses the importance of written consent being obtained but if this is not possible oral consent should be properly recorded in the patient's case notes, and the entry signed by the person who has obtained the oral consent.

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## 2.203 HUMAN TRANSPLANTS

The Human Tissue Act, 1961, extended, with a number of changes, the provisions of the Corneal Grafting Act to the use of any parts of the bodies of deceased persons, not only for therapeutic purposes but also for medical education and research. Guidance on the procedure to be adopted when making arrangements for transplants was circulated in a letter from the Board to Hospital Management Committees on the 17th May, 1971, and read:

'Following the publication of the Human Tissue Act, 1961, and the issue of Circular HM (61) 98, information was circulated to the Hospital Management Committees on the 20th November, 1961, giving advice on the action to be taken with regard to human transplants. This advice is still applicable, but at a recent meeting of the group secretaries it was agreed that it would be helpful if general guidance could again be given by the Board to Hospital Management Committees on the points to be covered when making arrangements for transplants. The following procedure, which meets with the approval of the Board's Medical Advisory Committee, is suggested for adoption:

1. In cases where in-patients inform hospital staff that they have made a written statement to the effect that they wish parts of their bodies to be used after death, the information should be suitably recorded in the case notes. In-patients should not, however, be asked to make bequests.
2. In cases, such as road traffic accidents, where it is evident that the patient has not long to live, discussions with relatives and the obtaining of their consent should be carried out by the consultant concerned or his deputy. The coroner should be brought fully into the picture when these approaches have been made.
3. Authority for the removal of parts of bodies must be given by the person lawfully in possession of the body. If the patient dies in hospital, then this is the Hospital Management Committee until such time as executors or relatives claim the body. Hospital Management Committees can designate persons to act on their behalf and it would seem desirable for hospital secretaries and their deputies to be designated under Section 1 (7) of the Act as officers responsible for giving authority (subject to the necessary consent) for the removal of parts of bodies after death for any of the approved purposes.

4. Where there is reason to believe that the coroner may require an inquest or port-mortem examination to be held, authority to remove parts of the body may not be given, nor may the parts be removed without the coroner's consent. It would, however, be desirable in all cases for hospital secretaries or persons designated by the Hospital Management Committee to consult the coroner before giving authority.
5. Before authority is given for removal of any part of the body, the responsible officer should satisfy himself:
  - (a) that where a request has been made by the deceased, there is no reason to believe that such request was subsequently withdrawn.
  - (b) that where the deceased has not made a request such reasonable enquiry as may be practicable has been made which would lead him to believe that the deceased in his lifetime had expressed any objection to this, or that the surviving spouse or any relative has any objection. In this connection the nearest relative available should be asked if he objects or has reason to believe that any other relative would object, but hospital authorities are not expected to ask the relative for a statement that no other relatives object. Every care must be taken to record and give effect to objections from patients or relatives, and objections made orally should immediately be noted in writing. The word 'relatives' is not defined in the Act and the Secretary of State considers that it should be interpreted in the widest sense to include those who claim a quite distant relationship to the deceased. Hospitals will have their own methods of recording objections but the officer authorising removal of parts of bodies must satisfy himself by a personal inspection of the records that proper enquiry has been made and that no objection has been lodged.
  - (c) that the authority to remove parts of a body is given to fully registered medical practitioners.
6. There may well be press enquiries when a transplant is arranged and care should be taken to ensure that the name of the donor is not disclosed without the consent of his close relatives.'

## **2.300 MENTALLY DISORDERED PATIENTS**

### **2.301 DETAINED AND INFORMAL PATIENTS ABSCONDING AND CAUSING INJURY TO PERSONS AND DAMAGE TO PROPERTY**

From time to time the Board have handled and advised upon claims arising from injury to persons or damage to property caused by detained and informal patients who have absconded. Generally speaking they relate to patients in psychiatric hospitals whose progress has been such that medical officers had granted leave of absence for short periods or otherwise permitted the patients to work in the hospital grounds without supervision. Varying circumstances require each case to be considered and dealt with on its particular merits.

Medical officers perform a statutory duty under the provisions of the Mental Health Act 1959. The Board have been legally advised that the duty of the Hospital Management Committee and its servants is to take reasonable care. What is 'reasonable' will be different in the case of each patient. There appears to be no distinction between the duty concerning an informal patient and that concerning a patient detained by due process of the law, save that in the latter case the patient may well be suffering from a worse or more dangerous mental illness, and so require additional care and supervision.

Counsel has given as his opinion that the committee and its servants would not be liable for any act of a patient which could not have been reasonably foreseen. This is only an application of the general common law principle relating to the liability of a person for negligence. Counsel's view that a committee and its staff would be liable for damages for negligence, for example, by granting leave to a patient who is known to be a pyromaniac and who damages somebody else's property by arson while on leave, is fortified by the provisions of Section 39 (1) of the Mental Health Act 1959 which specifically provides that 'the responsible medical officer may grant to any patient .... leave to be absent from the hospital subject to such conditions (if any) as that officer considers necessary in the interests of the patient or for the protection of other persons.' Counsel summarises this opinion by re-iterating that if the committee and its staff take reasonable care over supervising and granting leave to patients, they will not be liable for any damage which such patients may later cause whilst on leave or by escaping. It is thought that in many cases it may indeed be difficult for anybody who has suffered damage to prove negligence on the part of the hospital authority.

On the strength of this opinion the Board have successfully resisted a number of claims and satisfactorily dealt with isolated cases where particular circumstances have warranted special consideration.

## 2.302 STAFF ATTACKED BY PATIENTS

The possibility of attack or assault by a patient on a member of staff, particularly in psychiatric hospitals, must be accepted as an occupational hazard. The Department does not insure against risks of injury to its servants or agents but this does not deny a person the right to claim at common law against an individual, always provided that grounds for such a claim exist and can be established.

However, it is unlikely that a court would find against a fractious patient in a psychiatric hospital who caused such injury or damage. Insofar as Hospital Management Committees as employers are concerned, the Law of Master and Servant applies, whereby the master owes a certain duty of care to his servant and if there is a breach of the duty resulting in damage to the servant he can sue his master in negligence. It necessarily follows that in the absence of negligence and/or breach of statutory duty, a Hospital Management Committee is under no common law liability and the employee's only remedy is the right to benefit under the provisions of the Industrial Injuries Act and the provision which exists by way of sick pay under Whitley Council agreements, the possible application of the Criminal Injuries Compensation Scheme as referred to in a letter dated 22nd June, 1971, from the Department of Health and Social Security and, in cases of permanent incapacity, the superannuation and injury allowance arrangements of the National Health Service Superannuation Scheme.

While in the majority of cases where staff are attacked by patients, no negligence on the part of the Hospital Management Committee arises, it must be recognised that, as in other spheres, there always exists the exception to the general rule. One such case concerned an attack by a patient on a 62 year old female nurse. The following extracts from Counsel's opinion are worthy of note:

'The patient was a young man of 19 years of age who was plainly seriously disturbed. In the nursing reports throughout his short stay he is described variously as very disturbed, very abusive. On one occasion he threatened and attempted to strike a fellow patient. On another occasion he threatened violence to all and it was necessary to keep him under constant supervision. He frequently attempted to get out of bed and hit somebody. There were numerous other incidents. In my view the history of this patient indicated a need for particular care in his treatment. I do not think it was appropriate to require

a 62 year old woman, albeit an experienced nurse, to deal with him alone. The kind of attack which occurred ought in my view to have been foreseen as something which might well happen, and I do not think such a person could be expected to defend herself with the same efficiency as a younger male nurse.

In my view, the responsibility for administering the drugs to the patient ought not to have been given to her (the nurse), or to be more precise, should have been expressly given to another male nurse or done by the charge nurse. I ought to add that I am very conscious of the difficulties of obtaining suitable and sufficiently numerous nursing staff, particularly in the psychiatric field, and in due course there may arise for decision the difficult question of the extent of a Committee's liability when an accident is due simply to their inability to obtain staff with the resources available to them. But I do not think that this is such a case. The fault here (and I use the word fault in the legal sense and not by way of criticism of the persons concerned) was not to allocate existing resources so as to take account of the patient's known propensities. The decision of "Size v Shenley H.M.C. (QBD) O'Connor J. April 1969" is accordingly distinguishable on the facts.'

It follows from the foregoing that despite the extreme difficulties that may be experienced through staff shortages, every effort should be made to ensure that staff are deployed and duties allocated in the best possible way, bearing in mind the particular cases in any ward, so that risk of injury or damage is reduced to a minimum.

## **2.400 THE PATIENT – GENERAL**

### **2.401 COMMUNICATIONS BETWEEN DOCTORS, NURSES AND PATIENTS**

The failure of communications between doctors and nurses and their patients has led to claims being received for negligent treatment. In one case a patient had attended the casualty department for treatment of the middle finger of his right hand. An x-ray examination revealed a fracture of the middle phalanx and a collodion splint was applied. Just outside the building, the patient lit a cigarette and was horrified to see his recently applied dressing burst into flames. As a result of this the patient suffered first degree burns on his index finger and thumb. It subsequently transpired that the patient had not been warned of the inflammable nature of the collodion and a claim for damages could therefore not be resisted.

Another case illustrates the importance of ensuring that follow up treatment is arranged. A patient was re-admitted on three occasions for repeat cystoscopies and on the last occasion was referred for another check in six months' time. Unfortunately no action was taken subsequently by the hospital to arrange admission although the relatives stated that contact was made with the hospital who promised that arrangements were being made for re-admission. The patient alleged that due to the negligence of the hospital, he was subjected to unnecessary pain and suffering causing his health to deteriorate.

A report on 'Communications between Doctors, Nurses and Patients – an aspect of Human Relations in the Hospital Service' prepared by a joint committee of the Standing Medical and Nursing Advisory Committees was circulated to Hospital Management Committees with Circular HM (63) 60. This report looks at the problem of communications in some depth and it is most desirable that staff should be given an opportunity of studying the suggestions which are made.

The need for much closer contact between general practitioners and the hospital service has also been stressed by the Chief Medical Officer of the Department of Health and Social Security.



## 2.402 PATIENTS' PROPERTY AND LOST PROPERTY FOUND IN HOSPITALS

The Department from time to time have issued memoranda, notably Circulars HMC (49) 107, (56) 85 and HM(62) 2, about the responsibility of hospital authorities in relation to patients' property. It is the accepted principle that Hospital Management Committees should not accept responsibility for cash and valuables not deposited for safe custody and that patients should be advised accordingly.

Patients normally wish to retain certain personal items, and responsibility for these items which are retained in their physical control must be accepted by patients themselves. If, however, a particular patient is taken to the theatre for an operation, the hospital authority would be expected as bailee to accept responsibility for any items of this nature until such time as the patient is able again to exercise effective control.

In the case of patients' dentures or spectacles being broken or thrown away due to the negligence of the hospital staff, then the Hospital Management Committee would be expected to accept responsibility. Particular difficulty has, however, arisen in regard to alleged losses of hearing aids and it is advisable that when patients are admitted with expensive hearing aids, a note to this effect is entered on the case notes. This could avoid a difficult situation arising when a patient alleges that a hearing aid has been lost due to the negligence of staff.

With regard to lost property found in hospitals, the question arises as to how long this should be retained and, if not claimed, what means of disposal should be followed. The Department of Health and Social Security's view is this:

'The law relating to the finding of property is far from clear and it is not possible to give precise guidance. On the question of how long property found in hospitals should be retained we have been advised that the owner's right to have his property returned to him continues until the expiration of six years under the Limitation Act and this may possibly run either from the date when the property was sold or from the date when there was a request for the return of the property. It is obviously necessary to balance against the inconvenience of cluttering up hospital premises with lost property the risk that a claim will be made after a period of time. Where it is found necessary for administrative convenience

to dispose of property, disposal could take place when the police return the property if it had been handed to them or when they would have returned it had they accepted it. If the lost property is valuable, it may be convenient to produce an independent valuation of the property before it is sold in case a claim is made after, say, a year or two.

'As to entitlement, there is some authority for the proposition that the occupier of private premises is in possession of anything left on those premises, but the Department would not expect any hospital to press as against the finder any rights they may have as occupier of the premises.'

The following publications deal with the matter in greater detail:

'Patients' Property, Income and Allowances'. A research report prepared by the Welsh Branch of the Association of Chief Financial Officers in the Hospital Service in England & Wales (July 1963)—Offices of the Association, General Hospital, St. Helens Road, Swansea.

'Law Notes for Nurses' (S.R. Speller 7th Ed.) Royal College of Nursing, Henrietta Place, Cavendish Sq., W1M 0AB.

'Hospital Law' (S.R.Speller) — Published by H.K. Lewis & Co., 136 Gower Street, W.C.1.

## 2.403 CASE NOTES AND RECORDS

Mr. Bryan N. Brooke, in an article in the Lancet in 1962, wrote:

'How can the man who recorded the note guess that years later some investigator will require to know whether Pumpernikel's sign was present in cases of knock knee? Still more, how can he guess that for the future investigation to be valid he must state that it was not present; that the absence of a statement to that effect cannot fairly be regarded as evidence that the sign was absent? '

Although primarily referring to the purpose of medical records for research purposes, the comments equally apply to the importance of accurate case notes and records being maintained to enable claims affecting the treatment of patients to be considered. All the medical defence societies stress the importance of records and the following extract taken from the Annual Report 1970 of the Medical and Dental Defence Union of Scotland is particularly relevant:

'It often happens that a claim is made and the circumstances investigated some considerable time after the event which gave rise to it; it is not unusual to find that the practitioner involved had only a vague memory of the events or in some cases no recollection whatsoever. Since the success or failure of a practitioner's defence will rest on the evidence which can be produced to refute the charge it can be seen that the corner stone of that evidence might well be founded on the practitioner's record of the treatment and advice given, the technique employed and a note of any unusual occurrence which might have arisen at the time. It is often of importance to have it recorded that after due consideration and perhaps following discussion with other colleagues it was considered to be in the interests of the patient concerned that he should not be fully informed of the true situation. Good records therefore not only tend to be good practice they can be a doctor's or dentist's best defence.

'It should also be remembered that nursing notes can be of considerable value as they usually record in some detail a patient's progress and so disclose symptoms and signs which might not be readily apparent at the time when the doctor sees and examines the patient in the ward. Nursing notes can play a significant part in assessing the standard of care which a patient has received and this information might be accepted by a court as detrimental to the practitioner where nothing has been recorded by the

practitioner to counteract such inference.'

Inadequate clinical records, difficulties in deciphering reports and signatures, incomplete records, the absence of consent forms all add to the difficulties experienced by both the hospital authorities and defence societies in defending claims.

## 2.404 IDENTIFICATION OF BODIES

An incident occurring in one hospital has drawn attention to the fact that certain methods used to identify bodies failed to achieve their object: in many cases they depended on a label sewn on to the shroud. Since the shroud may have to be removed at some stage from the body confusion could arise, and the Regional Hospital Board have commended procedures to be followed by Hospital Management Committees. The methods described are not intended to displace those now used which are equally reliable provided that within these methods the body itself is also labelled and not only the shroud, coffin, or mortuary space. It should be emphasised that no method should be used to which there are expressed religious objections.

Where an identification band system is already in use in the hospital, the band should not be removed after death; if illegible, it should be renewed. The minimum identification details recommended are Christian name/s (in full), surname, hospital number and last ward or department.

If such a system is not in general use for routine identification of patients during life, a band should be affixed around the wrist or ankle after death.

In all cases the details will be written, or confirmed, by those staff laying out the body in the ward or preparing it for transfer to the mortuary (e.g. from the accident department): these details should always be checked by a second person.



## 2.405 ACCIDENTS TO VISITORS

Liability under this heading will normally be based on the provisions of the Occupiers Liability Act 1957. Under this statute the occupier of premises — and this includes hospital premises and hospital grounds — has a duty regarding the personal safety of everyone entering the premises. This means the common law duty to take such care within existing circumstances that visitors will be reasonably safe in using the premises for the purpose for which they are invited or permitted by the occupiers to be there. Most claims of this nature arise from alleged defects in roadways and approaches such as pot-holes, sunken stopcock box covers, drain covers etc.

It is appreciated that in most hospitals it would be difficult, if not impossible, to maintain all drives, hospital car parks and approaches in perfect condition. As mentioned above, the hospital authority's duty goes no further than to exercise reasonable care and foreseeability. The position was succinctly put in a judgment given by Mr. Justice Sellers in the case of 'Farrant v Lewisham Group H.M.C. (1956)' when he said:

'It is well recognised and the courts have demonstrated very frequently that people may fall without the fault being the fault of anybody else than the person who stumbles, and possibly, not the person who stumbles either. These accidents do happen in all sorts of places — on the highway, on pathways, in the home — and everyone has the potentiality of falling. Drives cannot be kept in perfect condition. The duty of such an institution as a hospital is to take reasonable care to have their approaches reasonably safe. But that does not mean that those who use those drives have not to meet with roughness here and there. We have to confront them on roads and even on our own premises, and, providing there is nothing that can be described as dangerous — something which is beyond that ordinary wear and tear which we all have to confront — then there is no breach of duty.'

Hospital Management Committees are reminded of the need for adequate external lighting in the hospital grounds, particularly where it is known that there is a possible hazard. Similarly it is important to ensure that any directional signs displayed indicate a safe way and that when any known temporary hazards exist adequate warning notices are exhibited.

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**PART 3**

**3.000**

**BUILDINGS, PLANT and GROUNDS**



### 3.001 BUILDINGS

#### 3.002 BUILDING OPERATIONS (LADDERS)

A considerable number of accidents involving hospital employees continue to be caused by falls from ladders and step ladders. In some cases the employees were 'the authors of their own misfortune' because they had failed to take the elementary precaution of ensuring that the ladder was properly footed or safely placed against the wall. In one case an employee leaned a step ladder against a wall as if it were an ordinary ladder. These cases apart, there were others where there was clear negligence by the employing authority. One ladder was so rotten that the upright snapped a foot from the ground while a painter was standing on the seventh rung.

In 1967 H.M. Factory Inspectorate undertook a survey of ladder accidents and the following extracts from a pamphlet published by the Department of Employment and Productivity, entitled 'Falls from Ladders' and based on the findings of the survey, are of particular interest.

The survey showed that the number of accidents was not related to the time of year in which they occurred. Accidents happened indoors and outdoors in about equal numbers. It is also significant that 5% of the accidents investigated occurred when the ladder was 10 ft. or less in length. Another widely held belief, that if the ladder is placed at the right inclination nothing will go wrong, was shown to be false. Nearly two thirds of the accidents occurred where the ladder had not been secured and the remainder were mainly due to over-balancing, slips on rungs and defective ladders. Defective ladders accounted for about 10%, and failure to carry out instructions to secure ladders, for 14% of the total of accidents. This, coupled with a lack of appreciation of the hazards involved, pointed to the need for supervision in ladder work. If the regulations relating to the use of ladders were at all times observed, there would be a sharp decline in the numbers of accidents.

When the report was analysed, the following pertinent features emerged:

**Unsecured Ladders.** Of the total, 53% of the accidents were due to unsecured ladders and more than half of these were caused by slipping at the base and a quarter by initial movement at the top. The first essential is to secure the ladder at the top and only where this is impracticable should it be secured or weighted at the base. Clear instructions to secure (with supervision to see that these are carried out) are also essential.

**Over-balancing and over-reaching.** One of the causes of accidents was that of over-balancing or over-reaching (14%) and this indicated that ladders were used as working places in unsuitable conditions. The use of mobile or temporary scaffolding or cradles would have prevented the falls.

**Duration of the job.** Of the total of accidents attributed to 'failure to secure,' 67% occurred where the job was of 30 minutes duration or less. There was a surprising number (50) in jobs lasting from ½ hour to 1 day and over, where no attempt whatsoever had been made to secure the ladder. One third of the injured persons gave the reason for failure to secure as 'short duration of job' and 'unaware of hazard.' If accidents are to be reduced the duration of the job should not be a factor in assessing the risk of an accident.

**Surface at ladder foot.** As would be expected, accidents happened when ladders were placed on hard or smooth surfaces both indoors and outdoors. In all cases there had been failure to secure.

**Defective ladders.** The report showed that accidents attributable to defective ladders (10%) occurred when there was no regular inspection — the defects could have been remedied in good time had proper inspection taken place.

The incidence of accidents arising from the use of ladders at hospitals throughout this region remains constant. The following cases extracted from those occurring in the region serve to emphasise the problem:

- (a) During the course of his employment a bricklayer standing on a ladder secured this to an iron balcony by means of a rope bond. The rope broke causing the man to lose his balance. He fell 35 ft. to the ground sustaining serious multiple injuries. In a subsequent action the Judge held that the hospital were negligent in not inspecting the equipment and condemning the defective rope. He also held that the hospital had not complied with the Statutory Regulations.
- (b) A hospital sister fell from a pair of steps sustaining serious injuries resulting in some permanent disablement. Evidence showed that the steps were defective and unstable and that there was no system in force for inspection of such equipment, it simply being left to the persons using the ladders to report any defect.

- (c) A painter fell from a ladder sustaining multiple injuries resulting in complete paralysis from the waist downwards. The ladder was unfastened, not properly footed and no person was stationed at the base to prevent slipping. Here again there was a breach of statutory regulations.
- (d) An accident occurred during the use of a step ladder to give access to a ceiling trapdoor. The ladder was not suitable for the particular task in that it was not high enough to reach the place of work and in the absence of a firm foothold there was no handrail at top level.
- (e) Injury resulted when the upright member of the back frame of a step-ladder split for approximately  $\frac{3}{4}$  of its length. It was unquestionably defective. It was immediately destroyed and the solicitors acting for the workman were denied the opportunity of carrying out an inspection. It is most important that all defective equipment giving rise to accidents should be carefully preserved.

When visiting hospitals throughout the region it has been noted that ladders continue to be painted. On one such visit it came to light that new ladders and step-ladders were being painted. Paint serves to cover up defects and if protection is required then only clear varnish should be used.

So far as the use of ladders is concerned Regulation 32 of the Construction (Working Places) Regulations 1966 is relevant and should be carefully studied. In a recent case, a ladder had not been securely fixed to its upper resting place in accordance with Regulation 32 (2) (a). The workman, an experienced plumber, denied any knowledge of the regulation and, furthermore, the building supervisor was not himself cognisant of this statutory obligation.

While it is believed that most hospitals now have a proper system for inspecting ladders and keeping a record of all such regular inspections, these should not be confined to equipment under the direct control of the building department. The inspection procedure, which ideally should be carried out under a planned preventive maintenance scheme, should extend to all ladders and step-ladders throughout the hospital premises. During investigation of an accident which occurred when a ladder collapsed while being used in a ward it had to be admitted that only ladders and step-ladders in the building store were subject to regular inspection.



### **3.003 BUILDING OPERATIONS (SCAFFOLDS)**

This is another aspect of building operations to which the Construction (Working Places) Regulations 1966 apply. These together with the Construction (Health & Welfare) Regulations 1966 replace all but a few of the former Building (Safety, Health and Welfare) Regulations 1948. Such cases as the Board have been called upon to consider have in the main been involved with the condition and/or suitability of the material used.

Regulation 9 lays down that every scaffold and every part thereof shall be of good construction, suitable and sound material and of adequate strength. Inter alia, timber used for scaffolds shall be of suitable quality and, as with ladders, step-ladders, trestles etc., must not be painted or treated thereby concealing possible defects. It cannot be too strongly emphasised that, as is the case with so many of these regulations, the duty imposed by Regulation 9 is absolute and is not one which has to be performed merely within the limits of knowledge and foresight.

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for light.

### **3.004 BUILDING OPERATIONS (ROOFS)**

An employee was working on a step ladder sited on the asphalt surface of a flat roof when one leg of the ladder penetrated the asphalt causing the man to fall a distance of three feet. Although the asphalt was in good condition, inspection revealed that there was deterioration of the roof timbers beneath. This situation was tantamount to 'an unsafe place of work' for which the employing authority is answerable. When instructing employees to work in places such as this, there is an onus upon the employer to make certain that the roof is capable of supporting the foot ends of ladders. In circumstances such as this it would be prudent to supply a suitable board or other load spreading surface capable of supporting the foot ends of ladders.

On a step ladder placed on the asphalt surface of a flat roof when one of the feet of the ladder was on the edge of the roof, the ladder tilted and the man fell a distance of three feet. Although the ladder was not damaged, inspection revealed that there was deterioration of the foot timbers between the rungs. The investigation revealed that there was deterioration of the foot timbers between the rungs. When the ladder was placed on the roof, the foot timbers were found to be in such a condition that they were unable to support the weight of the ladder. When the ladder was placed on the roof, the foot timbers were found to be in such a condition that they were unable to support the weight of the ladder. When the ladder was placed on the roof, the foot timbers were found to be in such a condition that they were unable to support the weight of the ladder.

### 3.005 GLAZING IN BUILDINGS

In 1969 a claim was made against a Hospital Management Committee following an accident resulting in quite serious injuries to a member of the nursing staff. The facts were that two other members of the hospital staff passed through a pair of swing doors in a corridor. Unaware that the claimant was immediately behind them, they allowed one of the swing doors to swing back. The claimant put up her hand to check the swing but as the door swung back her hand went through a glass panel about 15" x 10". Counsel for the management committee gave as his opinion that it was negligent of the two members of the staff to allow the door to swing back without first glancing behind them to see if anyone was following. This would have been an obvious and easy precaution to take. However, he did not think this was the direct cause of the accident. In his view the accident was primarily caused by the unsuitability of the 24 oz. or 1/10th glass panel in the door. This panel did not comply with Section 310D of the relevant Code of Practice (BSI. No. C.P.152: 1966) which provides:

'All glazing for doors, other than for small observation panels, should be toughened glass except where fire regulations apply.'

The panel in question plainly was not merely a small observation panel, and it was not toughened in any way at all.

The question then arose as to what action the Hospital Management Committee should be expected to take in order to comply with the recommendations made in the 1966 Code of Practice. It is clearly impracticable to alter every door and window in every hospital building and each building should be considered on its merits. Where a Hospital Management Committee are aware of obvious danger spots such as swing doors or other foreseeable vulnerable positions, they would be expected to act reasonably and replace existing panels with suitably toughened glass. Against this and where, in the judgment of responsible officers, there is unlikely to be an accident, even though the recommendations are not complied with, it would be reasonable to take no steps.

The above mentioned 1966 Code of Practice (as amended in 1967) also includes window glass. When designing and specifying glazing in buildings, the requirements of C.P. 152 1966, C.P. 153 Part One 1969

and Part Two 1970, and any subsequent amendments, should be incorporated in the design and specification as necessary.

### 3.006 PRECAUTIONS AGAINST PATIENTS FALLING FROM HOSPITAL WINDOWS

A Hospital Management Committee has recently enquired whether the Board have any policy with regard to fixing windows or affixing window bars to prevent, or to make it difficult for, patients to fall or throw themselves from upper floor windows. The broad answer to this problem is that Hospital Management Committees can only take reasonable and foreseeable precautions with special reference to children and mental patients. It may be of interest to recall proceedings which followed the death of a patient at a Cardiff hospital.

On the 7th August, 1955, a patient 'X' was admitted to St. David's Hospital for stabilisation of a diabetic condition, and on the morning of 8th August he was found lying dead on the ground, below an open first floor window through which he had apparently fallen. This window, of the sash type, was in a corridor along which 'X' had to walk to visit the toilet. The blocks had probably been removed when this window had been painted sometime previously, and had not been replaced. An action for damages was brought by the widow against the Hospital Management Committee, alleging negligence by the hospital staff in that, knowing that 'X', as a diabetic, was subject to bouts of air hunger and swaying, they had failed to ensure that the window, which he must pass, was blocked so as to prevent his falling out. The claim was resisted by the committee.

At the hearing, judgment was given in favour of the defendants, the judge stating that there was no evidence from the medical history that 'X' was subject to bouts of air hunger or swaying, or was suffering from a pre-diabetic coma, and that there was the greatest improbability that his fall from the window was due to these causes. He stated that in his view there was no breach of duty on the part of the Hospital Management Committee on any grounds arising from the unblocked condition of this window, as the patients accommodated on this floor of the hospital were neither children nor in a state of mental infirmity. He was of the opinion that there is no duty on the part of those who manage institutions of this type to prevent windows being opened to their full extent.

The judge commented: 'That a diabetic patient, or others for that matter, should be treated like children, and that windows would not be opened because of some unfortunate accident that had happened

previously, is going beyond a reasonable standard of care or foreseeable risk.'

In some hospitals within this region, where there are sash windows in the wards above ground level, these have been fitted with wooden wedges screwed into the frames and designed to limit the extent to which a window can be opened. In other hospitals, casement windows have been adapted to restrict the opening to a minimum. It is important, however, that any arrangements made do not constitute a fire hazard by restricting potential rescue operations.

### **3.007 MAINTENANCE OF CHIMNEYS USED AS FLUES FOR GAS FIRES**

A nurse died from asphyxia and carbon monoxide poisoning after sleeping in a room with the gas fire on. A rook's nest in the chimney was responsible for collection of poisonous fumes in the room, aggravated by lack of ventilation because the window was shut. A chimney in the same hospital was previously blocked by a bird's nest. Hospital technical officers are recommended to carry out periodic checks to ensure that chimneys which are used as flues for gas fires are kept clear of obstructions.



### 3.008 SAFETY SUPERVISORS

Hospital Management Committees are reminded of the necessity to appoint safety supervisors under the Construction (General Provisions) Regulation 1961, as referred to in a letter dated 13th December, 1965, from the Ministry of Health and in an earlier letter, dated 3rd December, 1963, from the Regional Hospital Board.

It should be emphasised that where works are being carried out by contractors under the Standard Form of Building Contract Local Authorities Edition without quantities and also with Clause 18 (i), the inspection of existing fabric by contractors or their sub-contractors before erecting scaffolding or ladders should be stressed in the bills of quantities or specification. The contractor is not responsible under Clause 18 (i) for injury to persons and property if it can be proved that this results from any act or neglect by the employer or any persons for whom the employer is responsible.



### **3.100 PLANT**

#### **3.101 ELECTRICAL EQUIPMENT AND APPLIANCES**

Two cases of electrocution focus attention on the care necessary in carrying out any work involving electricity.

A general handyman was installing a new power point in an unfrequented hospital corridor. He was discovered lying on the floor, electrocuted, with a power cable in his hand. In recording a verdict of 'death by misadventure', the coroner commented: 'There is no evidence of criminal negligence, but in large institutions with large and complicated electricity systems, there should be a good and sound system to label all power points clearly.'

Another case concerned a domestic assistant who suffered an electric shock and collapsed unconscious onto the floor while using an electric polisher. At the particular hospital there were several types of socket outlets, and because of this, short adaptor leads with plug tops required to be used in conjunction with electrical appliances, to provide the right conversion from one type of outlet to another. In this instance, the adaptor was from a 15 amp round pin plug to a 10 amp plug. Whilst the polishing machine and its integral lead were in sound condition, the extension lead was found to have worked loose, causing a short circuit which in turn made the machine 'live'. On inspection, the following faults were found:

- (1) There was no cord grip.
- (2) The cable was severely twisted. (This could have been due to misuse and poor storage).
- (3) The neutral and earth wires were not connected. This could have been due to pulling the cable beyond its limits.

The hospital engineer drew the following conclusions:

- (a) The equipment could have been tampered with by unauthorised persons.
- (b) Due to severe twisting and pulling, the two cables could have been disconnected and wound round the live conductor, making the machine live.
- (c) Because the earth conductor was not connected, the protection equipment would not operate.

Arising from this accident, the hospital inspection system was tightened up and a notice circulated to all employees in the group drawing attention to the care which should be exercised in the use of electrical

appliances and stressing the importance of reporting any suspected faults.

Some years ago, in one of his annual reports, the Chief Inspector of Factories, commenting on the large number of electrical fatalities, pointed out that the greatest number of fatal accidents occurred at pressures not exceeding 250 volts, thereby refuting the theory held by many, including electricians, that the risk at this voltage is negligible.

Recommendations for ensuring safety in hospitals which have been prepared by the Regional Hospital Engineers' Association include the following:

All portable electrical equipment must be constructed and used in a manner approved by the group engineer.

There should be adequate socket outlets for equipment to be used within a reasonable radius of the supply points. Temporary wiring installations should be avoided; in particular, the practice of using long electrical leads should be discouraged. Leads and plugs associated with electrical equipment should be periodically examined for safety. All electrical defects, including lighting and fuse failures, must be reported to the engineering staff.

In the interests of safety of patients and visitors and employees, adequate lighting should be maintained at all times. With the development of deep plan building, design intent should be fulfilled by proper use of the artificial lights to the standard required. When replacing fluorescent lamps it is important to check whether special colour-rendering characteristics are required.

In 1958, following a hospital fire, guidance was issued by the Board to all Hospital Management Committees on the use of electric irons in laundries. This read:

The Ministry's electrical safety engineers suggest that cordless type irons, with a thermostat and which stand on a specially constructed plate, are safer than those with cords. A neon-type lamp could be provided to indicate when the current is turned on.

### 3.102 LIFTS

While throughout the region there have fortunately been very few accidents involving lifts, one which did occur proved expensive and involved the particular Hospital Management Committee in a four-figure settlement.

An employee sustained injury when attempting to open the car gate of a hospital passenger lift. The gate appeared to stick but, when pressure was exerted, opened suddenly throwing the employee off balance and causing a neck injury. Previously, following inspection of the lift by an insurance engineer-surveyor, it had been reported that the lift gate lock needed replacement. Due to a combination of circumstances, more than two years elapsed before the work was put in hand and completed and meantime the employee met with her accident.

After the inspecting engineer's report, it was decided to enter into a maintenance contract and the firm concerned were instructed to fit new gate locks. But the work was not put in hand because of staff changes, the instruction was not followed up and the delay was still further perpetuated. It should have been a simple matter to implement the inspecting engineer's original recommendations. Had this been done within a reasonable period, the employee concerned would have been spared a painful and permanent partial injury, and the Hospital Management Committee the trouble and expense of prolonged negotiations and the payment of damages and costs.

The case emphasises how essential it is that no time should be lost in implementing the recommendations of inspecting engineers. It is known that in some hospitals the hospital staff carry out lift maintenance, while others enter into maintenance contracts with independent firms of lift engineers. Maintenance contracts are optional and can cover varying amounts of work. Their use and nature depend on the location of the lift and the competence of the hospital's own maintenance staff, but the overall effect should be that all the items listed in the Department of Health and Social Security Electrical Maintenance Manual PMG/12 are carried out (the 15 three-weekly items include attention to gate locks) and any defects not immediately remedied reported to the hospital engineer for attention and follow up action.

If hospital staff do routine maintenance themselves, it would seem desirable for a specialist firm (preferably

the maker) to carry out any renewals of or repairs to components, as distinct from simple adjustments.

In accordance with Circular HM (51) 40 and HM (55) 20 Hospital Management Committees are reminded that it is necessary for all lifts to be regularly examined and tested under arrangements made with insurance companies.

### **3.103 HOT WATER PIPES AND OTHER HEATING APPARATUS**

Among recommendations made by the Regional Hospital Engineers' Association for ensuring safety in hospitals is the following:

The natural curiosity of children necessitates additional precautionary measures: special attention needs to be paid to the protection of exposed heating pipes, and radiators and sterilisers should be protected by strong guards. Electrical socket outlets should be of the shuttered type.

Hot water taps, if not fitted with a thermostatic control, should preferably have detachable handles and the regular maintenance of electric switches and power points is important.

The Board's experience adds weight to these recommendations at least in-so-far as they apply to hot water pipes, since there have already been two cases where children have been injured while playing in a waiting room. They came into contact with some large exposed heating pipes running the length of the room and situated a foot or so above floor level.

These comments apply with equal force to areas of hospitals occupied by adult patients, as shown by a group who reported three accidents in which patients in wards in general hospitals sustained burns by coming into contact with unguarded central heating hot water pipes.

# AND OTHER RECOMMENDATIONS

Recommendations made by the Hospital Board's Group

1. In addition to the recommendations made by the Hospital Board's Group, the following recommendations are made:

2. The installation of exposed heating pipes and radiators should be such that they are not likely to be damaged by children.

3. Radiators should be fitted with a thermostatic control.

4. The installation of electric switches and power points is important and should be such that they are not likely to be damaged by children.

5. It is recommended that the installation of electric switches and power points should be such that they are not likely to be damaged by children.

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### 3.104 SMUT AND SMOKE DAMAGE – CLEAN AIR ACTS 1956 and 1968

The Circular HM (63) 42 drew the attention of hospital authorities to the provisions of the Clean Air Act, 1956, and advised them that Section 22 (1) of the Act, in effect, requires National Health Service hospitals to comply with the Act subject to the sanction of a Ministerial enquiry. The Clean Air Act, 1968, extended the provisions of the principal Act, and Regulations brought the Act into full operation on 1st October, 1969.

In November, 1969, the Department of Health and Social Security issued a reminder of the need to secure maximum compliance with the Clean Air Acts and pointed out that the Acts empower local authorities to report to the Secretary of State any cases of emission from National Health Service hospitals of smoke, grit or dust which, but for the immunity of the Crown, would be offences under the Acts. The Secretary of State has responsibility for enquiring into the circumstances and, if cause for complaint is revealed, for using all practicable means to prevent or minimise the emission and to prevent a recurrence.

A number of claims have arisen from alleged smut emission from boiler chimneys causing damage:

- (a) In one case complaints were made to a Member of Parliament and the local medical officer of health. Corrosive smuts emitted from a new boiler plant caused damage to the paintwork of a car parked in a roadway in the vicinity of the hospital. Other complaints in the same area concerned damage to paintwork of houses and garments on garden clothes lines. To prevent a nuisance occurring again, it was subsequently found necessary to approve capital expenditure for the erection of a new chimney and installation of a chemical injection unit. A later complaint from householders in the vicinity of this same hospital was attributed to attempts being made to burn plastic material in an incinerator. There have been no further complaints since alternative arrangements were made for disposal of plastic materials.
- (b) This case differs from the former in that it resulted in damage to a car parked within the confines of the hospital premises. Following a change-over from solid fuel to oil-firing there was consistent trouble from smut emission. This was most marked during the night. The oil company were asked to investigate and suggested a change to lighter, albeit more expensive, oil. In addition, staff were

issued with a notice prohibiting parking of cars in the vicinity of the boiler house.

- (c) Corrosive smuts emitted from an oil-fired boiler chimney caused damage to a car parked in the vicinity of the boiler house. The group engineer reported that such complaint was not unknown in plant of this type, but had not previously occurred at this particular hospital where the design of the combustion chamber and flue were not of a type to give rise to such emission as a regular feature. Smut emission for short periods can arise when the boilers change over and cold flue conditions are prevalent. There is no doubt these smuts are highly corrosive and can cause damage particularly to paintwork whether on metal or woodwork.

On the wider issue of 'smoke' as distinct from 'smut' emission, the Department have suggested the former can unnecessarily be caused by inefficient operation of furnaces and stress the desirability for all hospital stokers to be trained to the standard of the Boiler Operator's Certificate (vide HM (66) 20). The Department have further commented that 'a useful and comparatively cheap aid in the control of offensive emissions is the smoke density meter. In a considerable proportion of the larger hospital boilers such meters have already been fitted, and it is recommended that as well as including them in new or replacement plant, hospital authorities should endeavour to provide them for existing boilers using heavy oil or coal capable of producing more than 1 million BTU/hour of heat.'

### 3.105 LAUNDRIES

Hospital laundries are subject to the general provisions of the Factories Act, 1961, and Section 71 specifically mentions laundries. Statutory Rules and Orders also extend the Act's obligations and stipulate provision of suitable protective clothing. Those sections of the Act dealing with guarding of dangerous machinery are applicable when considering such machinery as callenders, steam presses, etc. which have been responsible for numerous accidents, some with most serious consequences. The importance of fencing every part of transmission machinery, and maintaining such fencing, cannot be too strongly emphasised. Maintenance of floors, passages and stairs should be constantly borne in mind, with special reference to the fencing of openings in floors.

In one such case, a laundry supervisor sustained injury when she tripped over a gully cover which had been removed and the opening not protected while certain installation work was being carried out. Even when all necessary precautions have been taken, accidents can occur in circumstances over which the employing authority have no control but for which, nevertheless, they are liable.

A woman employee was operating a small steam press controlled by press buttons necessitating the use of both hands and removing the hands from the danger area when the press descends. Another employee, mistakenly thinking she was being helpful, came from behind the machine operator and pressed the starter buttons just at the time when the operator's hands were on the press straightening a piece of work, causing injury to the operator's hands.

Those hospitals which now have laundry monorail systems will be familiar with the accidents which can occur through hooks and bags falling on operatives. Accidents of this kind can only be avoided by constant and vigilant inspection and maintenance. The monorail systems come within the definition of 'lifting machines' under Section 27 of the Factories Act, 1961, and subsection (2) lays down that:

'All such parts and gear shall be thoroughly examined by a competent person at least once in every period of fourteen months and a register shall be kept containing the prescribed particulars of every such examination; and where the examination shows that the lifting machine cannot be used with safety unless certain repairs are carried out immediately or within a specified time, the person making the report

of the examination shall within twenty eight days of the completion of the examination send a copy of the report to the Inspector for the district.'

In order to comply with this provision, Hospital Management Committees concerned should enter into insurance inspection contracts.

### 3.106 WHEEL CHAIRS

A number of accidents have arisen from the use of wheel chairs. In some instances, patients have fallen from chairs simply because they have been left unattended and no attempt made to secure them in the chair or take other precautionary measures. These circumstances apart, in one case an elderly patient with a foot injury was placed in a chair with one wheel missing and nearly fell out. By a coincidence, on attending the out-patients department on the following day, he was placed in the same chair with the wheel still missing and, when he leaned forward to scratch his toe, the chair toppled forward, causing him to fall out. He sustained a fractured hip.

Investigations by the Board confirmed that there was no system for inspecting invalid chairs and like equipment, which continued in use until breakdown necessitated some action. Apart from the loss and suffering occasioned to the patient by this kind of mishap, the resultant legal liability can prove expensive. In the interests of all concerned, there is everything to be gained by hospitals instigating proper maintenance and inspection systems.

The above remarks apply with equal force to other similar equipment — for example sani-chairs, mobile geriatric chairs etc.



## **3.200 GROUNDS**

### **3.201 FALLING TREES IN HOSPITAL GROUNDS**

Attempts have sometimes been made to hold Hospital Management Committees liable for damage occasioned by trees and branches, situated in hospital grounds, falling on to the highway, neighbouring premises or buildings. The law appears to be that the occupier of land is not liable if a tree which he did not know, and had no reasonable grounds for knowing, to be unsafe, falls and causes injury or damage to persons or adjoining property. Landowners and occupiers have a duty to act with reasonable care to prevent trees on their property from becoming a danger.

If it is apparent by visual examination that a tree or its branches are decaying, then there would be a duty on the occupiers to take measures to prevent the trees causing injury or damage. For example, in a case where an elm tree fell and injured the driver of a car and his wife, the property owners were held liable, because good estate management involved the trimming of trees. Just before the accident, the owners of the tree had given orders for it to be lopped and topped. This had not been done for many years and if such action had been taken at the appropriate time, the accident would almost certainly have been avoided.

Hospital Management Committees may therefore feel the need to introduce a system providing for regular inspection of trees and perhaps the ideal would be for this to be undertaken annually.

## CRITICAL GROUNDS

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### **3.202 WEATHER CONDITIONS, SNOW AND ICE**

Weather conditions play their part in producing accidents. One claim considered by the Board's working party was by a domestic assistant who alleged that when reporting for duty she slipped on ice within the entrance gates to the hospital. Her legal advisers alleged that ice and snow had lain on the entrance way for two days before the accident and no attempt had been made to clear it. They submitted that this failure constituted a hidden danger and 'unsafe way' for which the hospital authority were liable.

On another occasion an employee was using a pathway between the wards when she slipped and fell on an area of ice. This was brought about by a leakage from an outside tap the washer of which needed renewing. This again stresses the duty of the hospital authority to maintain a 'safe means of access.'

Whereas it is accepted that it is not always possible to take immediate effective measures to counteract weather conditions, there is nevertheless a duty on occupiers of premises to take reasonable steps to clear accumulation of snow and ice as soon as possible.

## THEY, SNOW AND ICE

by their part in producing accidents. One claim could be made by a defendant who alleged that when reporting to an official, Her legal advisors alleged that ice and snow had been removed and no attempt had been made to clear it. This might be a 'unsafe way' for while the hospital authority might be using a gateway between the wards, the employee was brought about by a leaking from a water tap. It is not always possible to take immediate action, but it is nevertheless a duty to clear it as soon as possible.

### **3.203 ANIMALS ON THE HIGHWAY**

The following case will be of interest to those Hospital Management Committees involved in farming activities. A herd of cows belonging to a hospital was being driven from a field on to a road. The herd emerged without any warning and, although a car being driven along the road braked hard, there was a collision with one of the cows. The exit from the field was considerably overgrown and, indeed, a vehicle driver some 30 yards from the exit would not have been aware of the existence of the gateway. The cowman in charge of the herd admitted that the animals were driven on to the main highway with no warning to traffic travelling along it and that he had no visibility of the roadway owing to the thickness of the hedge. Unquestionably, there should have been another drover preceding the herd who could have warned the motorist or kept the cows under control.

It is accepted law that a person leading or driving animals along a highway is under a duty to take reasonable care to prevent damage to other users of the highway or to property adjoining the highway. In short, when cattle are driven along a highway they must be kept under proper control and for this purpose the owner/s must employ an adequate number of persons. Such number would depend on the extent of the herd but in any event should be a minimum of two persons, one at the head and the other at the rear of the cattle, and during the hours of darkness suitable warning lamps should be provided. In this particular case the cowman in charge was employed by a firm who contracted with the Hospital Management Committee to milk and attend the herd. The contract provided indemnity to the Hospital Management Committee in respect of accidents and the insurers concerned ultimately accepted responsibility for settlement of the resultant third party claim.

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### **3.300 BUILDINGS, PLANT AND GROUNDS – GENERAL**

#### **3.301 FACTORIES ACT 1961 – APPLICATION TO CERTAIN HOSPITAL PREMISES**

From time to time enquiries are received from Hospital Management Committees as to the application of the Factories Act 1961 to certain hospital premises and the work undertaken therein.

As its title indicates the Act applies to 'factories'. Broadly speaking, and as defined in Section 175 (1) of the Act, 'factory' means any premises in which, or within the close or curtilage or precincts of which, persons are employed in manual labour in any process for, or incidental to, any of the following purposes:

(a) the making of any article or part of any article, or

(b) the altering, repairing, ornamenting, finishing, cleaning or washing, or the breaking up or demolition of, any article, or

(c) the adapting for sale of any article,

being premises in which the work is carried on by way of trade or for purposes of gain.

Under Section 175 (2) the expression 'factory' also includes, inter alia, premises in which persons are employed in manual labour (even although such premises are not factories within the meaning of Section 175 (1) ).

Section 175 (9) is important, in that it lays down that any premises belonging to or in the occupation of the Crown or any municipal or other public authority are not excluded from the operation of the Act even though the work carried on thereat is not by way of trade or for the purposes of gain.

It seems clear that certain parts of hospital premises are brought within the scope of the Factories Act and that this applies, for example, to laundries, boiler rooms, engineering or building works departments. A hospital kitchen is not considered to be a factory within the meaning of the Act (*Wood v L.C.C.* 1940).

A district inspector of factories when visiting a hospital in this region in connection with the Offices, Shops & Railway Premises Act 1963, took note of some maintenance workshops used by the hospital maintenance staff to carry out repairs, including some painting of movable items of wood-work and preparatory work in connection with maintenance of water, heating, steam and electrical services in the hospital. The inspector maintained that these workshops come within the scope of the Factories Act 1961 and asked the group secretary to complete Form F.9 'stating that certain premises are being used as a

workshop.' In support of his contention the inspector quoted Sections 175 (1), 175 (2) (k) and 175 (9) of the Act.

The matter was referred to the Department of Health & Social Security who in 1967 were considering issue of 'General Guidance on the application of the Act to Hospitals.' Such advice was deferred because of proposals for new legislation then being considered by the Department of Employment & Productivity. Meantime, hospital authorities who are in doubt as to the effect of the Act in particular circumstances were advised to refer their enquiries to the local factory inspectorate whose instructions should normally be followed.

Another case concerned a small building separate from the main building of a psychiatric hospital and used exclusively for industrial therapy. Patients are engaged on assembly work received from factories and comprising light plastic work such as assembling toys in packages. On reference to the local Factory Inspectorate a definite opinion was given that these industrial therapy departments come within the requirements of the Factories Act.

The Department have also, inter alia, advised that the Factories Act, 1961, applies to the following departments:

Hospital medical photographic departments where photographs or cinematograph films taken for hospital purposes are developed and/or printed.

Hospital pharmaceutical departments when manufacturing procedures, as distinct from dispensing of pharmaceutical preparations or the breaking of bulk supplies, are carried out on a substantial scale.

Central sterile supply departments.

Hospital dental laboratories.

H.M. Factory Inspectorate should be notified on Form F.9 of the occupation of premises used for these purposes.

Until such time as general guidance is issued by the Department, hospital authorities faced with specific cases are advised to adopt the general principle: 'When in doubt accept the local factory inspector's ruling.'

### **3.302    UNGUARDED FLOOR OPENINGS**

The Board are concerned at the number of accidents occurring throughout the region due to employees falling into unguarded openings in floors, passageways and roadways, in or about hospital premises. All too often investigations reveal that while warning notices and guards have been available, they have not been brought into use until after the event. To quote but one such case. Maintenance of some underfloor services was in progress in a corridor at a point within two feet of a pair of swing doors. The opening in the floor remained completely unguarded, and no steps had been taken to warn people using the swing doors that work was in progress.

A domestic employee came along the corridor drawing behind her a cleaning machine. When she reached the swing doors she held them open with her back to draw the machine through the door space. She took one step back and fell into the unguarded opening almost on top of the employee working below. Leaving aside the question of portable guards in this particular instance and bearing in mind the nearness of the swing doors to the opening in the floor, it would have been prudent to have temporarily secured the doors or alternatively stationed another employee near them to give the required warning to persons using the corridor.



### **3.303 PROTECTIVE CLOTHING**

Over the years numerous claims have been made by employees for exposure to special risks in the course of their employment. These have all been cases in which the employees have developed skin trouble as a result of contact with detergents or other washing-up substances. All too often the complaint has been that no protective gloves or other clothing were supplied.

The common law duty of an employer dictates that, if the nature of the work is such that a reasonable employer would provide his workmen with some protective device or clothing while doing the work, there is a duty to provide it and take reasonable care to see that it is used.

In certain cases the duty becomes a statutory obligation and the following are relevant to hospital building operations and laundries:

#### **Building Operations — Construction (Health & Welfare) Reg. 1966 No. 15**

Every contractor shall provide adequate and suitable protective clothing for any person so employed who by reason of the nature of his work is required to continue working in the open air during rain, snow, sleet or hail.

#### **Laundries Welfare Order 1920**

The occupier shall provide and maintain in good and clean condition, for the use of all persons employed in processes involving exposure to wet, suitable protective clothing, including waterproof boots or clogs, and also, for persons engaged in sorting soiled linen, suitable overalls or aprons with bibs, and armlets from wrist to elbow. The occupier shall provide and maintain for the use of all the persons employed suitable accommodation for clothing put off during working hours, with adequate arrangements for drying the clothing if wet. The accommodation so provided shall be placed under the charge of a responsible person and shall be kept clean.

Apart from these statutory regulations, Hospital Management Committees are also reminded of their obligations under the Ancillary Staffs Whitley Council Conditions of Service to provide protective clothing. Care should of course be exercised by Hospital Management Committees to ensure that protective clothing supplied is used by the staff concerned and maintained in satisfactory condition.

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### **3.304 VEHICLES USED WITHIN HOSPITAL PREMISES**

The importance of regular inspection of all types of vehicles can be illustrated among a variety of cases by an accident which occurred when a hospital porter sustained serious injuries when he was run down while using a manuelectric refuse truck. The truck was being led down a slope. The speed of the vehicle increased, but when the brakes were applied they failed to hold, and, on examination, were found to be defective. The engineering staff who serviced these vehicles relied to a large extent on information given by the operators regarding apparent defects. No record of servicing was kept. A proper inspection system was initiated, detailing all servicing, with date and signature of the employee responsible for the maintenance.

The question of the method of inspection is dependent upon local arrangement, but the onus of providing an effective system rests with Hospital Management Committees.



**PART 4**

**4.000**

**CATERING and DOMESTIC MANAGEMENT**



## **4.000 CATERING AND DOMESTIC MANAGEMENT**

### **4.001 ACCIDENTS IN HOSPITAL KITCHENS**

Accidents in hospital kitchens are all too frequent and arise from a variety of causes, although mainly resulting in burns, scalds and slipping. Here are some examples:

- (a) An employee crossing a kitchen slipped and fell sustaining a wrist injury. The cause of the accident was the presence on the floor of damp bread thrown from a mixing machine. This machine was not provided with any collar or shield to prevent spraying of the contents, which in fact spread some way across the floor space between the machine and the sink.
- (b) A cook went to a large pan in the kitchen to whisk custard which was being prepared. He raised the lid which was counter balanced by a weight on a chain, and while he was leaning over the pan the lid fell striking his head and trapping his hands due to a fault in the chain supporting the counter weight. There was no regular system of inspecting such equipment, it being left to employees to report defects as and when they became apparent. Arising from this occurrence, a regular inspection system is now in operation.
- (c) A dining room porter loading a steam operated stove with food from the kitchen operated a sliding door which became detached from its runners and fell on the foot of a domestic who was standing nearby.
- (d) An assistant cook passing a steamer slipped on condensation which had collected on the floor in front of the steamer where a grating and gully were situated to carry away any spillage when the door was opened. Unfortunately, the grating did not serve its purpose when the door was opened to its full extent and in those circumstances condensation dropped from the door to the floor about a foot from the grating thereby creating a hazard. The position was remedied by extending the grating to take in the area exposed with the steamer door fully opened.
- (e) An assistant cook slipped on a kitchen floor. As she fell to the ground her right arm came into contact with a hot plate. Although the switch was in the 'off' position, a defect caused the electrical current to reach the hot plate. As a consequence the employee sustained burns. It was known that the switch was giving trouble and had more active measures been taken to deal with

this, the particular injury would not have occurred.

- (f) A night porter lit a gas burner under a frying pan containing cooking oil although it was not part of his duties to carry out this operation. He then left the kitchen unattended and on his return discovered the pan had overheated and the oil was in flames. In carrying the pan to a sink he slipped, the burning oil splashing on to his hands and singeing his hair and eyebrows. Following this occurrence, Hospital Management Committees were asked to ensure that foam type extinguishers and asbestos blankets are situated near each fish fryer.

These cases illustrate the importance of kitchen staff being properly instructed on the correct use of equipment and also the necessity for regular inspection.

Most accidents in kitchens have resulted from employees slipping on food or other matter. Some result directly from defects in equipment. Apart from those cases already listed, there was the instance of a cook who sustained injury when he slipped and fell on a wet floor. This was not a case of spillage occurring during preparation and serving of meals. This accident occurred long after cleaning operations had been completed and was due to water leaking on to the floor from the inlet pipes of a tilting kettle. This trouble had frequently occurred and emphasises the need for regular inspection of equipment to ensure that it is properly maintained.

Two cases have been contested in the courts. Both actions were based on allegations that the employees slipped on grease, fat or spillages of food during busy periods of preparation and service of meals. Judgment was given in favour of the Hospital Management Committees concerned, who were able to prove that they had taken all reasonable measures to keep kitchen floors free from substances likely to cause persons to slip. What constitutes reasonable measures must always depend upon the particular circumstances of each case. However, it would appear that the time factor is important. While it would not be reasonable to expect all spillages etc. to be immediately removed in the height of cooking and serving preparations, it is the duty of the employing authority to ensure that prompt cleaning systems are in force as soon as circumstances permit.

#### 4.002 CLEANING OF URNS AND VENDING MACHINES

Care should be exercised in the cleaning of beverage vending machines and urns supplying milk, tea and coffee. Vending machines should be cleaned in accordance with the manufacturer's instructions.

The importance of care being taken in the cleaning of urns is illustrated by an accident when a student nurse, lunching rather late, asked for a cup of black coffee. She was served from an urn which had contained black coffee, but shortly before she was served, it had been filled with hot water and a cleaning powder. On drinking the 'coffee' the student nurse received painful burns to her throat.

Model instructions for the cleaning of urns for milk, tea and coffee, were issued by the Board on 30th March, 1965, and read as follows:

- (a) Cleaning must take place only when service of beverages has finished, after each meal of the day.
- (b) Before beginning to clean out the urns for milk, etc. ensure that the machine is safe by shutting off heat control valves or switches.
- (c) The urns to be cleaned should be emptied of all remaining milk, coffee, coffee grounds etc.
- (d) Rinse out the urns and any connecting pipes and taps with clean warm water only.  
At no time during routine cleaning should detergent or cleaning powders, soaps or de-scaling agents be put into the machine.
- (e) Remove all milk and coffee adhering to the inside of the urns with a firm bristle brush kept specially for this purpose. Remove and dismantle taps, brush and wash in clean water.
- (f) Re-assemble taps and replace, then rinse out urns several times and leave to dry out.

When staining of urn linings occurs, or de-scaling becomes necessary, report this to the maintenance engineer. These cleaning operations should be part of regular planned maintenance and should not be carried out by catering staff.

Specially shaped brushes for cleaning out beverage equipment are usually available from the manufacturers of beverage making equipment; alternatively they can be obtained from factors and wholesalers of catering equipment.



#### **4.003 SLIPPING ON FLOORS**

Most complaints of accidents caused by tripping or slipping on floors are based on allegations of highly polished surfaces mainly in wards and corridors while others have arisen from alleged defects in floor coverings such as linoleum and carpets. Those involving slipping mostly occurred in hospitals which used polish with a wax content. Accidents have been less marked where slip retarding polish has been substituted for the orthodox wax variety. The matter is of the greatest importance, particularly in orthopaedic wards. One such case concerned a patient of 62 years of age who, following treatment for a fractured left femur, was encouraged to walk around the ward using crutches. Because of the highly slippery state of the floor, one of the crutches slipped causing the patient to fall as a result of which she suffered fractures of both wrists. This was not an isolated case in the particular ward and pending the possible provision of an alternative floor covering, the use of polish was discontinued.

It seems almost elementary to say that polish should not be used to excess and, indeed, as suggested above, there are cases where it is necessary to seek an alternative to the application of polish. A suitable liquid detergent for washing floors is available through central supply arrangements. Polishes should also be obtained through central supply arrangements and guidance on the use of such polishes is given on page 4231 of the National Health Service Hospital Supply Catalogue.

Accidents have also occurred through people tripping over or skidding on mats. Often the mat is found to serve no useful purpose and could be dispensed with. Where the necessity does arise then consideration should be given to sinking a properly fitting mat in a well in the floor.



## PART 5

5.000

### INSURANCE and INDEMNITIES



## 5.000 INSURANCE AND INDEMNITIES

### 5.001 INSURANCE

The provisions of HMC (51) 42 and HM (55) 20 permit hospitals to insure steam vessels, lifts and similar specialised equipment in order to ensure that they are regularly and competently inspected. No other form of insurance is permitted. Thus the Department carries its own risk for third party, motor cases and for such things as employers' liability, fidelity guarantee, personal chattels of patients and staff, liability for negligence.

In motor cases the question has frequently been raised by Hospital Management Committees as to whether it is necessary to insure hired vehicles while hospital vehicles are undergoing maintenance or repair. In such cases hired vehicles can be considered as on hospital service and treated in exactly the same way as hospital vehicles and covered by H.M. Treasury Agreements. This also applies to any passengers or patients travelling in the hired vehicle.

It is, however, thought advisable to remind Hospital Management Committees that insurance should be effected in respect of any liability which might otherwise fall to be met out of free monies. The wisdom of this ruling became apparent in a case involving injury to a member of a band which visited a hospital to entertain patients. The bandsman claimed damages after he fell while negotiating a pathway which was in an admittedly poor condition. Not until a settlement of the claim had been agreed did it come to light that the Hospital Management Committee had effected a public liability insurance giving indemnity in respect of a contingency of this nature. In spite of the delay in notification of the claim to the insurers concerned, they agreed to reimburse the Hospital Management Committee in full the sums paid in respect of damages and the claimant's costs.



## 5.002 PERSONAL PROTECTION INSURANCE

Following a recent case brought against a group secretary who occupied a house in hospital grounds it transpired that the secretary held a personal protection insurance which, inter alia, gives indemnity for claims arising from the ownership of a dog.

The particular claim concerned injury to a patient allegedly caused by the behaviour of the dog while being exercised within the hospital premises. Eventually proceedings were instituted jointly against the group secretary and the Hospital Management Committee. The claim was settled by the committee on their own behalf and that of the group secretary and efforts then made to obtain a contribution from the secretary's insurers. However, they took the view that, had the accident occurred anywhere other than within the hospital premises, the secretary would have been indemnified by the legal principle of 'scienter' and there could have been no possible claim against him.

The insurers maintained that in the particular circumstances a claim arose only because of the secretary's association with the hospital premises and the application thereto of the Occupiers Liability Act. They further argued that the risk is one never contemplated by the terms of their policy which expressly excludes indemnity for accidents 'arising out of the insured's trade, profession or business.' This exclusion was applied because, but for the secretary's residence within the hospital premises, the animal owned by him would not have been exercised on the premises.

This case is cited as a precautionary note to hospital staff who occupy residential accommodation and hold personal liability policies. They could be living in a fool's paradise in thinking they would be indemnified in respect of accidents occurring on hospital premises. Staff finding themselves in this situation are advised to approach their insurers to ascertain the extent of cover afforded by their policies and whether these do provide adequate indemnity.

It is appropriate to remind Hospital Management Committees that in accordance with the provisions of Circular HM (56) 31, staff should be warned, both by public notice and individually when taking up appointment, that no responsibility can be accepted for articles lost or damaged on hospital premises whether by fire, burglarly, theft or otherwise, with the exception of money, jewellery or other small valuables which have been handed over to the hospital authority and for which a receipt has been given.

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### **5.003 VOLUNTARY HELPERS IN HOSPITAL – INSURANCE**

Hospital authorities have been asked from time to time to take every opportunity to increase the scope of voluntary effort in hospitals and to encourage personal voluntary services. Some voluntary organisations have insurance cover of various kinds which could include their members while working in a hospital. Others have no such insurance.

The Department recognise that a requirement of an indemnity on the part of voluntary organisations and others undertaking personal voluntary service could be a potential obstacle in the way of voluntary service. The policy of the Department is, therefore, that where voluntary workers are carrying out in good faith work in accordance with arrangements made with the hospital authority, it is to be expected that the latter will act towards them as it would towards its own staff. This means that the authority would, if satisfied that it should properly do so, stand by the voluntary worker in any legal action for loss or damage and reimburse damages that may be awarded.

## 72 IN HOSPITAL - INSURANCE

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#### 5.004 INDEMNITIES

Many Hospital Management Committees have local contracts for the provision of services etc. which contain indemnity clauses. There have been cases where this fact has been overlooked or where the Regional Hospital Board have been notified at a very late stage. It is therefore important when reporting accidents and claims to the Board to state whether contracts of this nature exist.

From time to time enquiries have been received from Hospital Management Committees concerning the giving of indemnities to local health authorities and other organisations in respect of services given to hospitals, and obtaining indemnities from similar organisations and/or individuals using hospital premises. The types of indemnity vary considerably and the Board will advise on an appropriate wording for any particular indemnity required.



**CLASSIFIED INDEX**



<i>Classification</i>		<i>Page No.</i>
	<b>A</b>	
2.405	Accidents to visitors — liability to provide reasonably safe conditions in roads, etc. . . . .	53
2.403	Accuracy of case notes and records . . . . .	49-50
3.203	Animals on the highway . . . . .	87
2.302	Attacks on staff by patients . . . . .	43-44
	<b>B</b>	
2.109	Bedsores . . . . .	25
2.106	Blood transfusions . . . . .	15-16
2.404	Bodies — identification of . . . . .	51
3.105	3.104 Boiler rooms — smut and smoke emission . . . . .	77-78
3.002	3.302 Building — guarding of openings in floors . . . . .	79,91
	3.003 ladders and scaffolds (a) need for inspection and maintenance . . . . .	55-57,59
	3.002 (b) need to secure . . . . .	55-57
3.002	3.003 (c) need for workmen to know Regulations . . . . .	55-59
	3.004 (d) use of ladders on roofs . . . . .	61
	3.303 provision of protective clothing . . . . .	93
	3.008 safety supervisors . . . . .	69
	3.005 use of toughened glass in doors and windows . . . . .	63-64
	3.006 windows — precautions against patients falling from . . . . .	65-66
	2.107 Burns — diathermy . . . . .	17-21

*Classification*

*Page  
No.*

**B (continued)**

4.001	Burns — in kitchens . . . . .	97-98
2.002	during operations . . . . .	3

**C**

2.403	Case notes and records . . . . .	49-50
3.203	Cattle . . . . .	87
2.110	Children in hospital — care and custody . . . . .	27-28
3.007	Chimneys used as flues for gas fires — inspection of . . . . .	67
2.104	China left in wounds . . . . .	11
2.002	Claims, handling of in co-operation with medical defence societies . . . . .	3
3.104	Clean Air Acts, 1956 and 1968 . . . . .	77-78
4.002	Cleaning of urns and vending machines . . . . .	99
2.107	2.401 Communications between doctors and nurses and patients: . . . . .	17,20-21,45
	warning about nature of treatment (i.e. undue heat) . . . . .	17,20-21
	2.401 dressings (i.e. inflammability) . . . . .	45
	2.401 need to ensure follow-up treatment is arranged . . . . .	45
	2.401 need for close contacts with patients' general practitioners . . . . .	45
	2.201 Consent to treatment — age for consent . . . . .	33
	2.201 consent of spouse, etc. when patient . . . . .	
	is unconscious . . . . .	33
	2.201 guardian's consent . . . . .	33
	2.201 parental refusal . . . . .	34-35
	2.202 special forms for sterilization . . . . .	37

*Classification*

*Page  
No.*

**C (continued)**

2.201	Consent to treatment — standard form . . . . .	33
2.302	Criminal Injuries Compensation Scheme . . . . .	43

**D**

3.104	Damage from smut and smoke emission . . . . .	77-78
2.301	Detained and informal patients absconding and causing injury and damage . . . . .	41-42
2.301	medical officers' statutory duty to take reasonable care, legal opinion of 'reasonable' . . . . .	41-42
2.107	Diathermy apparatus — fire hazards . . . . .	19-20
2.107	need to warn patients to report undue heat . . . . .	17,20-21
2.107	use during operations . . . . .	17-20
4.003	Domestic — cleaning and polishing of floors . . . . .	101
4.001	kitchens . . . . .	97-98
3.105	laundries . . . . .	79-80

**E**

3.101	Electrical equipment and appliances — need for care in use of . . . . .	71-72
3.101	reporting of faults in . . . . .	71-72
3.202	Engineering — duty to take reasonable steps to clear snow and ice . . . . .	85
3.302	guarding of floor openings . . . . .	91



<i>Classification</i>		<i>Page No.</i>
	<b>F (continued)</b>	
2.002	2.104 Foreign bodies — left in accident injuries . . . . .	11
	2.103                      left in patients' bodies . . . . .	3,9-10
	2.102 Fractures and plasters . . . . .	7
	 <b>G</b>	
	3.007 Gas fires — inspection of chimneys used as flues for . . . . .	67
	2.104 Glass — in wounds — radio opacity . . . . .	11
	3.005 Glazing — use of toughened glass in doors and windows . . . . .	63-64
	 <b>H</b>	
	2.107 Hazards — fire — diathermy apparatus . . . . .	19-20
	4.001                      kitchens . . . . .	98
	2.105                      injections . . . . .	13
	3.103 Hot water pipes and other heating appliances — safety of patients . . . . .	75
	2.203 Human transplants . . . . .	39-40
	 <b>I</b>	
	3.202 Ice and snow — weather conditions . . . . .	85
	2.404 Identification of bodies . . . . .	51

*Classification*

*Page  
No.*

**I (continued)**

5.004	Indemnities . . . . .	109
2.302	Industrial Injuries Act . . . . .	43
2.301	Informal patients - absconding and causing injuries and damage . . . . .	41-42
2.105	Injections — hazards of . . . . .	13
4.001	Inspection — kitchen equipment . . . . .	97-98
3.105	laundry equipment . . . . .	79-80
3.102	lifts . . . . .	73-74
3.304	vehicles . . . . .	95
5.001	Insurance — general . . . . .	103
5.002	personal protection — staff . . . . .	105
5.003	voluntary helpers . . . . .	107

**K**

4.001	4.003	Kitchens — burns, scalds and slipping . . . . .	97-98	101
	4.001	fire precautions . . . . .		98
	4.001	inspection and maintenance of equipment . . . . .		97-98
	4.001	spillage on floors . . . . .		97-98

**L**

3.002	3.004	Ladders . . . . .	55-57,61
	3.105	Laundries — dangerous machinery . . . . .	79-80

<i>Classification</i>		<i>Page No.</i>
	<b>L (continued)</b>	
	3.105 Laundries — Factories Act 1961 . . . . .	79-80
	3.105 fencing of floor openings . . . . .	79
	3.105 fencing of transmission machinery . . . . .	79
	3.105 inspection and maintenance of all equipment . . . . .	79-80
	3.105 maintenance of floors, passages and stairs . . . . .	79
3.105	3.303 protective clothing . . . . .	79,93
	2.108 Lifting of patients . . . . .	23-24
	3.102 Lifts — inspection . . . . .	73-74
	2.402 Lost property found in hospital . . . . .	47-48
	<b>M</b>	
	3.301 Maintenance — application of Factories Act 1961 to workshops . . . . .	89-90
	2.405 hospital roads, car parks, paths, etc. . . . .	53
	3.007 inspection of chimneys used as flues for gas fires . . . . .	67
	4.001 kitchen equipment . . . . .	97-98
	3.002 ladders . . . . .	55-57
	3.105 laundry equipment . . . . .	79-80
	3.102 lifts . . . . .	73-74
3.105	3.302 need for guarding floor openings . . . . .	79,91
	3.004 roofs on which ladders are to be used . . . . .	61
	3.304 vehicles . . . . .	95
	3.106 wheel-, sani-, and mobile geriatric chairs . . . . .	81
2.002	2.101 Medical defence societies . . . . .	3,5

*Classification*

			<i>Page No.</i>
	<b>M (continued)</b>		
	2.110	Medical — care and custody of children in hospital . . . . .	27-28
	2.401	communications with patients . . . . .	45
2.201	2.202	completion of consent to treatment forms . . . . .	33-35 37
	2.104	foreign bodies — in accident injuries . . . . .	11
	2.103	resulting from operations . . . . .	9-10
	2.105	injections — hazards of . . . . .	13
	2.403	need for accuracy of case notes and records . . . . .	49-50
	2.107	care when using diathermy apparatus during operations . . . . .	17-19
	2.401	contact with patients' general practitioners . . . . .	45
	2.002	negligence . . . . .	3
	2.102	plasters and fractures . . . . .	7
	2.301	reasonable care to be taken when granting leave of absence to informal patients . . . . .	41-42
	2.403	Medical records . . . . .	49-50
	<b>N</b>		
	2.002	Negligence . . . . .	3
	2.105	Nursing — administration of drugs . . . . .	13
	2.302	attacks on staff by patients . . . . .	43-44
	2.109	bed sores — nursing procedures . . . . .	25
2.002	2.106	blood transfusions . . . . .	3 15-16
	2.110	care and custody of children in hospital . . . . .	27-28

<i>Classification</i>		<i>Page No.</i>
	<b>N (continued)</b>	
	Nursing — case notes, need for accuracy . . . . .	49-50
	2.401 communications with patients . . . . .	45
2.201	2.202 consent to treatment forms, completion of . . . . .	33-35 37
	2.107 diathermy apparatus . . . . .	17-21
	2.111 duty of care for suicidal patients . . . . .	29-30
	2.404 identification of bodies . . . . .	51
	2.105 injections, hazards of . . . . .	13
	2.108 lifting of patients . . . . .	23-24
	2.402 patients' property — responsibility for valuable property when patient is taken to theatre — care needed in dealing with patients' dentures, spectacles and hearing aids . . . . .	47-48
	2.102 plasters and fractures . . . . .	7
	2.002 swabs, accounting for . . . . .	3
	2.112 unconscious patients . . . . .	31
	3.106 wheelchairs and similar equipment . . . . .	81
	<b>O</b>	
	2.405 Occupiers Liability Act . . . . .	53
	2.101 Operations — safeguards — joint memoranda of Medical Defence Union and Royal College of Nursing . . . . .	5

# *Classification*

		<i>Page No.</i>
	<b>P</b>	
2.302	Patients — attacks on staff . . . . .	43-44
2.112	care of unconscious patients . . . . .	31
2.401	communication — doctors and nurses . . . . .	45
2.301	detained and informal — absconding and causing injury and damage . . . . .	41-42
3.006	falling from windows, precautions against . . . . .	65-66
2.108	lifting of . . . . .	23-24
2.402	property of . . . . .	47-48
2.111	suicidal — duty of care . . . . .	29-30
5.002	Personal protection insurance — staff . . . . .	105
2.102	Plasters and fractures . . . . .	7
3.303	Protective clothing — building operations — laundries . . . . .	93
	<b>R</b>	
1.000	Recording and reporting of relevant facts . . . . .	2
2.403	Records and case notes . . . . .	49-50
3.004	Roofs — use of ladders on . . . . .	61
	<b>S</b>	
3.101	Safety — electrical equipment and appliances . . . . .	71-72
3.103	hot water pipes and other heating appliances . . . . .	75

*Classification*

		<i>Page No.</i>
	<b>S (continued)</b>	
4.001	Safety — kitchen equipment . . . . .	97-98
3.105	laundries . . . . .	79-80
3.102	lifts . . . . .	73-74
3.008	supervisors . . . . .	69
2.112	trolleys . . . . .	31
3.106	wheelchairs . . . . .	81
3.104	Smut and smoke damage . . . . .	77-78
3.202	Snow and ice — need to take reasonable steps to counteract . adverse weather conditions . . . . .	85
2.302	Staff — attacks on by patients . . . . .	43-44
5.002	personal protection insurance . . . . .	105
2.202	Sterilization — consent by patient and spouse . . . . .	37
3.104	Stokers — training of — smut and smoke emission . . . . .	77-78
2.111	Suicidal patients — duty of care — 'Selfe v Ilford HMC', 'Thorn v Northern Group HMC' . . . . .	29-30
4.003	Supplies — suitable materials for cleaning floors . . . . .	101
2.002	2.103 Surgical instruments — accounting for . . . . .	3,9-10
2.002	2.103 Swabs — accounting for . . . . .	3,9-10
	2.103 differentiation between internal and external . . . . .	10
	2.103 joint memoranda of Medical Defence Union and Royal College of Nursing . . . . .	10

*Classification*

			<i>Page No.</i>
	<b>T</b>		
	2.106	Transfusions — blood . . . . .	15-16
	2.203	Transplants — human . . . . .	39-40
	3.201	Trees — liability for damage caused by falling trees — need for inspection . . . . .	83
	2.112	Trolleys — safety side rails and locking wheels when used for transporting unconscious patients . . . . .	31
	<b>U</b>		
	4.002	Urns and vending machines — cleaning of . . . . .	99
3.105	3.302	Unguarded floor openings . . . . .	79 & 91
	<b>V</b>		
	3.304	Vehicles — inspection and maintenance of . . . . .	95
	4.002	Vending machines and urns — cleaning of . . . . .	99
	2.405	Visitors — accidents to . . . . .	53
	5.003	Voluntary helpers in hospital — insurance . . . . .	107

*Classification*

		<i>Page No.</i>
	W	
3.202	Weather conditions — snow and ice . . . . .	85
3.106	Wheelchairs — inspection and maintenance . . . . .	81
3.006	Windows — precautions against patients falling from . . . . .	65-66
2.101	Wrong operations . . . . .	5











